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INSIDE

RELIAS MEDIA

Patients Leaving AMA: Signed Forms Alone Are Not Sufficient Malpractice Defense

The number of patients leaving EDs against medical advice (AMA) is rising dramatically, according to a recent report.[1] About 352,000 California ED visits ended before their medical care was complete in 2017, an increase of 57% since 2012.

"We have seen a significant increase in the number of patients who are leaving AMA," reports **Matthew DeLaney**, MD, associate professor and assistant residency program director in the department of emergency medicine at UAB Medicine in Birmingham, AL. This is likely due to longer wait times.

AMA discharges can be "quite a dangerous situation, both for the patient and the provider," says **Christopher B. Colwell**, MD, chief of emergency medicine at Zuckerberg San Francisco General Hospital and Trauma Center.

The potential for malpractice litigation exists anytime an adverse event occurs after an ED visit. "This potential increases when the encounter is not viewed by the public as 'routine," says **Robert Broida**, MD, FACEP. An AMA discharge is a prime example of this. "The three pillars of protection against patient refusal suits are a positive, understanding, and caring attitude; excellent communication; and proper documentation," says Broida, COO of Physicians Specialty Ltd.

For patients leaving AMA, a signature on a form "is icing on the cake. But the other pillars must be present," Broida stresses. The best way for emergency physicians (EPs) to avoid AMA lawsuits, says Broida, "is to understand that this is always going to be a part of our practice and to build proactive risk reduction techniques into your everyday routine."

An EP offers a carefully considered recommendation: Further evaluation, or hospital admission, is needed. The patient's response: *"No, I really just want to sleep in my own bed tonight."*

This patient is "likely to be perceived as difficult," says **Jay M. Brenner**, MD, FACEP. "These negative, subjective

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feelings can lead to litigation." Most EPs are committed to shared decision-making, says Brenner, medical director of the ED at Upstate University Medical Campus in Syracuse, NY. When the patient's reasoning seems questionable, though, EPs worry about both the medical outcome and the possibility of litigation. Some turn to empty threats, warning that insurance will refuse to cover the ED visit if the patient leaves AMA. "This is a myth and can be construed as coercion," Brenner cautions.

Brenner says even handing the patient an AMA form to sign can create animosity: "It may stigmatize the patient such that they are less likely to return for further treatment."

There are some factors making a malpractice claim involving an AMA discharge more defensible:

• Good documentation showing the patient had decision-making capacity. "What it really comes down to, for us in the ED, is determining whether a patient is able to make rational decisions," Colwell says. Plaintiff attorneys can find many reasons to argue the patient lacked capacity (medical conditions, dementia, drugs, and alcohol among them). "There isn't any one true objective measure or test we can do that legally defines capacity," Colwell explains. "It comes down to the EP's judgment."

Many ED charts address the issue of capacity sparsely: *"Alert and oriented × 3,"* or *"Awake and repeats my instructions."* This is not enough to refute an allegation that the patient was confused, intoxicated, or otherwise unable to make rational decisions. "You can be oriented and still not have capacity," Colwell notes. "People can sign a form, but not have capacity."

Nursing notes such as *"the patient is acting confused"* or *"doesn't answer questions appropriately"* can contradict the EP's charting. This is very problematic for the defense. "Statements like this in the nursing notes need to be directly addressed before signing someone out AMA," Colwell cautions.

Also problematic are comments that make it seem the EP was angry at the AMA patient, such as *"Patient continues to be very difficult, and won't do what I tell him."*

"This is not a good look for the jury. The jury will then question the EP's decision-making," Colwell says.

Simply noting that the patient "understood" offers little legal protection, according to DeLaney, who offers this example of good documentation as to capacity: *"The patient is clinically sober, free of distracting injury, appears to have intact reason, insight, and judgment. In my view, the patient can make decisions."*

• Evidence that the EP encouraged the patient to stay. Finding solutions to practical problems is the safest approach, Brenner says: "Patients are more likely to heed your advice if you truly understand their perspective and respect them as an individual."

If a chest pain patient wants to leave, DeLaney asks if they would be willing to stay for additional cardiac biomarkers. If the answer is no, he offers to arrange an appointment to see a primary care physician or cardiologist. If the ED chart is reviewed later, it reflects that the EP was "willing and able to come up with an alternative plan," DeLaney says.

One patient with septic arthritis and a history of IV drug abuse was about to leave AMA. DeLaney asked why and learned the true reason was

worry over what might happen to the patient's dog if the patient was hospitalized. "We were able to call a neighbor who agreed to take care of the dog, and the patient agreed to stay in the hospital," DeLaney recalls.

• Documentation that the patient knew it was possible to return to the ED anytime. A patient with intact medical decision-making capacity has a right to refuse any evaluation, test, or procedure. "Patients exercising that right should not be automatically perceived as confrontational," Broida says.

It is important to convey that the patients' wishes are respected and that the ED remains available to care for them should they change their minds, Broida adds.

Of 194 ED patients who left AMA, 31 returned to the ED within 72 hours, according to the authors of a recent study.[2] Of that group, 15 were found to have significant clinical findings, including pulmonary embolism and further progression of cardiac ischemia. The findings were not too surprising to **David Jerrard**, MD, the study's lead author: "It just verified that these were patients we were concerned about. We wanted to continue the workup, and for the vast majority, to admit them to the hospital." Notably, 25 of the AMA patients reported reluctance to return to the same ED for fear of embarrassment. Jerrard routinely reminds AMA patients that the ED is always open, and they can come back at any time.

• Evidence showing that patients and/or family truly understood the risk of leaving. Patients cannot be expected to possess the same level of medical knowledge as ED providers. "It is essential to clearly communicate the importance of medical tests or treatment when these are believed necessary," Broida advises.

EXECUTIVE SUMMARY

More patients are leaving EDs against medical advice (AMA), and signed forms will not necessarily prevent malpractice lawsuits. This documentation makes lawsuits more defensible:

- The patient's capacity was assessed adequately;
- The EP explained specific risks of leaving;
- The EP made efforts to convince the patient to stay, and encouraged the patient to return to the ED.

The ED chart should reflect that the EP "had a fairly involved discussion with the patient on the risks they face should they leave," says Jerrard, an associate professor of emergency medicine at University of Maryland School of Medicine.

Ideally, nursing and physician notes agree on this point. "It is a very tough case for the plaintiff to win when all of the clinicians chart the risk/benefit discussion and the ED's desire to care for them," Broida says.

• Evidence that the EP did everything possible for the patient. "EPs should do whatever possible to limit bad medical outcomes of patients leaving AMA," DeLaney says.

Some EPs worry that if they arrange care outside the ED for an AMA patient, it increases legal risks. The opposite is true, says **Laura Pimentel**, MD, clinical professor in the department of emergency medicine at University of Maryland School of Medicine. The EP facing an AMA discharge will reduce risk, she says, "by arranging the most effective and expeditious outpatient care possible." Well-documented attempts to make a follow-up appointment, answer questions, or provide medications are good examples. These efforts are not always in the ED chart.

"It is important that the medical record reflects the sincere efforts of the physician to continue to care for the patient even if the patient insists upon leaving," Pimentel stresses. DeLaney says statements like this can help the ED defense team: *"I offered to provide more pain medication to the patient. I asked the patient to stay in the hospital for serial abdominal exams. I offered to perform an ultrasound instead of a CT scan. I discussed these concerns with the patient's daughter, who is at bedside. She cannot convince the patient to stay for further evaluation."*

• A good AMA form. A shared decision-making approach goes beyond just signing an AMA form, Jerrard says: "That is really not sufficient to protect you from a legal standpoint."

If the plaintiff's expert finds a well-designed, completed AMA form in the ED chart, it could dissuade the attorney from pursuing a malpractice case that was not very strong to begin with. "But nothing is airtight," Pimentel says. If the case is compelling, the form is not enough to stop a lawsuit, especially if the form was poorly executed.

"The worst example of an AMA form that I recall is one that was very minimal," Pimentel says. The succinct form stated: *"I acknowledge that I am leaving the hospital at my own insistence and against the advice of my attending physician."* The form included signature lines for the patient and a witness, but nothing else. Another problematic

AMA form attempted to list every bad outcome one could imagine: death, heart attack, stroke, blindness, disability, paralysis, and more. "To me, that was too contrived and not at all customized to the patient's actual condition and situation," Pimentel says.

Some ED charts state, *"Patient was told he could die if he leaves."* Better documentation, according to DeLaney: *"I told the patient that if he leaves and has appendicitis, he could become critically ill, which could lead to disability or death."*

There are many ways the plaintiff attorney could bring the hospital into litigation involving an AMA discharge. "The plaintiff may use the actions or inactions of hospital staff that contributed to the patient's decision to leave AMA." Some examples: Failure of the hospital staff to recheck vital signs or perform neurological checks, or failure to follow up on orders placed by a provider at triage. If hospital factors contributed to delays in care or unacceptable waits, the hospital will "definitely be a named defendant," Pimentel warns.

There always is a risk of a successful AMA lawsuit. The best way to prevent it, Broida says, "is proper care and documentation so the plaintiff attorney will choose not to pursue the case in the first place." ■

REFERENCES

1. Reese P. As ER wait times grow, more patients leave against medical advice. *Kaiser Health News*, May 17, 2019. Available at: http://bit.ly/325i0hy. Accessed July 1, 2019.
2. Jerrard DA, Chasm RM. Patients leaving against medical advice (AMA) from the emergency department — disease prevalence and willingness to return. *J Emerg Med* 2011;41:412-417.

Legal Risks for EPs Responding to In-House Codes

A 55-year-old man coded a few hours after C4-C5 disk surgery. "He was in his hospital room when he sat up in bed to take a pain pill and had a choking episode," says **Susan Martin**, Esq., executive vice president of litigation management and loss control at Fort Lauderdale, FL-based Best Practices Insurance Services.

The man became unresponsive, and a code was called. "The emergency physician arrived just as the patient was being bagged by another physician," Martin explains. The surgeon had been called and was on the way to the hospital. The EP believed the patient was intaking adequate oxygen with the bag valve mask but could not see anatomical structures due to surgical swelling in the patient's neck. When the surgeon arrived, he performed a tracheotomy. The patient survived, but with some neurological deficits.

"The lawsuit alleged the ED physician should have put in a secure airway by any means to prevent hypoxia," Martin reports.

The EP testified that he did not know what surgery had been performed and was not comfortable putting a hole in the neck or releasing the sutures, risking severe hemorrhage and harm to anatomical structures. The surgeon agreed with this at deposition and was not critical of the EP. The case went to a jury, who found the hospital negligent for giving medication orally, causing the patient to experience a choking episode.

"No negligence was found as to the ED physician," Martin notes. The jury agreed that the EP had an obligation to "do no harm" in this situation and that the EP had made a reasonable decision to wait for the surgeon. Especially helpful to the defense was the entry in the ED chart indicating that the patient was *"moving air via AmbuBag."*

"Documentation of a patent airway was key in this scenario," Martin says.

EXECUTIVE SUMMARY

EPs often respond to in-house codes in other hospital areas. Some legal risks in this scenario:

- EPs might be accused of failing to secure the patient's airway.
- Sometimes, EPs are unaware of the patient's correct DNR status.
- Incorrect timing of events makes it appear care was delayed.

Unique Legal Risks

EPs face unique legal risks when responding to codes in the ICU, labor and delivery, or elsewhere in the hospital. "Attending physicians are

usually not available," Martin says. The EP must rely on staff or family to obtain a quick history of the patient's status, reason for admission, and pertinent medications (if needed).

"Post-surgical patients are most challenging," says Martin, noting that ED physicians also must rely on unit crash carts and whatever emergency equipment is available. "In busy times in the ED, unless there are multiple physicians staffing the ED, the response to codes can be challenging."

EPs cannot leave the ED unattended if other patients need immediate care. Most contractual agreements allow EPs to respond to codes as long as there are no patients with critical or emergent needs in the department. "But the ED physician's first responsibility is to the patients in the ED," Martin stresses.

Code Status at Issue

If a patient has a do not resuscitate (DNR) order in place, the EP should not receive a call for a code for that patient in the first place (at least in theory). "But once they get a call for a code, the EP has to act on that," says **Doug Williams**, JD, a partner in the Baton Rouge, LA, office of Breazeale, Sachse & Wilson.

This can happen because the patient's DNR status is unknown at the time the code is called. Because of the urgency of the situation, the EP would not be in a position to explore whether the patient is full code or DNR. "But if the emergency physician shows up, and all of a sudden there's a family member there who says, *'Wait, Mom is a DNR,'* that puts the EP in a difficult spot," Williams explains.

If the EP has not yet resuscitated the patient, the EP should stop their efforts once they become aware the patient is a DNR, Williams says. But if the DNR patient has been resuscitated successfully, "it is not up to the emergency physician to reverse their successful efforts," Williams says. It then becomes a separate issue, legally speaking — "the patient's power of attorney to determine as to whether life-sustaining treatment will be withdrawn," as Williams puts it.

One More Collateral Issue

Williams has seen other issues arise in medical malpractice litigation involving EPs' response to in-house codes:

- Which provider (the EP or the respiratory therapist) was supposed to be intubating the patient;
- Whether intubation was performed in a timely manner (and if not, why);
- Whether medication ordered was readily available.

In one case, the automated medication dispenser was not stocked with a reversal agent. The patient sustained a hypoxic injury. It was very doubtful that the slight delay in obtaining the medication caused the bad outcome. "But it was one more collateral issue in a case with poor documentation. The totality of the negative inferences played a role in the outcome," Williams notes.

Inaccurate records on the timing of events also can arise. It is critically important that the recorder is taking events down as they occur accurately. "I don't believe I've ever seen a code response that wasn't done extremely well. What I have seen is a code sheet that failed to tell the story, which created collateral issues in the litigation," Williams recalls.

While some of these cases have been defended successfully, others have resulted in payment to the claimant. In some cases, the person documenting during a code used multiple clocks to make timed entries. The problem is that computers, wall clocks, and wristwatches are not always synchronized.

"Two or three minutes difference can make it look like care was delayed, when it's not the case," Williams says.

Inconsistencies with recorded times appearing in various places in the chart cause similar problems. One nurse might chart a set of events, and another nurse charts the same events — but with slightly different times. This does not mean anything was done wrong, but it looks like care was delayed.

"I have settled cases where I honestly didn't believe anything was done wrong. But the charting wasn't telling the provider's story and was averse to them," Williams adds. ■

Factors That Could Make Quality Assurance Process Discoverable in Malpractice Litigation

Creating a robust quality assurance (QA) process will reduce malpractice risk for ED groups, according to **Andrew Lawson**, MD, FACEP. This is because it can identify practices that put EPs at risk for lawsuits.

As director of QA and quality improvement for two decades for the EP group at Mission Hospital Regional Medical Center in Mission Viejo, CA, Lawson regularly reviewed charts of patients who returned to the ED within 72 hours. Such review can reveal some concerning trends. One example is patients with tachycardia returning to the ED frequently. Another is patients returning with elevated white count and ultrasounds suggestive of cholecystitis. "Additionally, I would see certain physicians with a string of patient complaints," Lawson says. This allowed for individualized education on ways to reduce dissatisfaction.

Laws normally protect the QA process from discovery during litigation. However, plaintiffs challenge this often. Email is one common pitfall. "Few people realize that essentially all email correspondence is potentially discoverable when used in the QA process," Lawson advises. "I have seen cases in which email has been discoverable." If email is necessary, Lawson says to avoid using patient names and instead use a modified medical record number.

"Any good plaintiff lawyer will use any argument they can muster to convince a judge of discoverability regarding hospital QA information," Lawson notes.

Often, QA documents are protected under state peer review privilege statutes. They also may be protected under the Patient Safety and Quality Improvement Act, a federal law.

"However, EMTALA actions are federal actions," says **Danielle M. Trostorff**, JD, a healthcare regulatory and compliance lawyer at New Orleans-based Degan, Blanchard & Nash. Federal courts may not recognize state peer review privilege when determining discoverability of peer-review protected information. "Peer review documents in a federal EMTALA case may be discoverable," Trostorff notes.

The resulting Centers for Medicare and Medicaid Services/Office of Inspector General investigation should make the peer review documents confidential, according to Trostorff. These should be marked as "peer review, not subject to further disclosure."

"A Freedom of Information Act request should not be able to access those documents," she adds. These factors make it more likely the defense will avoid discovery of QA documents:

- Careful documentation of the peer review process;
- Early assertion of the applicable privileges;
- Rationale for protection of documents;
- Maintenance of a privilege log.

A privilege log and any internal review and documentation should be generated through a peer review committee, marked as peer review and kept in a peer review file. "Or, the trail of documentation should clearly point to the peer review process," Trostorff offers. The ED group and the hospital will be represented by different lawyers and will be treated as separate parties in the lawsuit. This can complicate the defense of both the individual EP defendant and the hospital. Normally, an ED group may have a strong partnership with the hospital's QA team. During litigation, this changes. "You are not on the same team," Lawson says.

The interests of an EP independent contractor and hospital, if co-defendants, are not always aligned. "EPs need to work with the hospital to ensure all QA processes involving ED care are protected from legal discoverability," Lawson says. ■

Did Patient Contract MRSA in ED? Maybe, But It Is Almost Impossible to Prove

Patients with methicillin-resistant *Staphylococcus aureus* (MRSA) can contaminate ED environments, according to the authors of a recent study.[1] Researchers examined 42 adult ED patients with evidence of MRSA colonization. They obtained cultures from patients and then gathered cultures from up to 16 surfaces in ED rooms. This occurred after patient discharge, but before disinfection of the rooms. Of the 25 rooms occupied by patients with MRSA, 19 contained one or more MRSA-contaminated environmental surfaces.

This raises the question: What if an ED patient acquired a MRSA infection from a contaminated surface? It might seem like a successful lawsuit against the hospital would be imminent. However, **David Talan**, MD, FACEP, FIDSA, is unaware of a single case with this fact pattern.

"There's evidence that MRSA exists in the ER, and there's a small chance patients could acquire a nosocomial infection even during their short stay in the ED," notes Talan, chair emeritus of the department of emergency medicine and faculty in the division of infectious diseases at Olive View-UCLA Medical Center in Sylmar, CA. Still, making a malpractice lawsuit out of that is surprisingly difficult. "It is theoretically possible, but it is virtually impossible to prove," Talan says. "I have never seen it come up in a case involving ED care." There are many hurdles to overcome to prevail in a med/mal lawsuit with this fact pattern. A plaintiff attorney would need to subpoena the hospital's infection control records and would have to find evidence that there were known outbreaks of MRSA infections in the ED. The attorney would need to prove the plaintiff contracted MRSA from the ED and not someplace else, a virtually impossible task.

"People can come in contact with bacteria from all sorts of mechanisms outside the hospital," Talan says. "You'd need epidemiologic proof."

The plaintiff attorney would need to discover a cluster of patients in a certain amount of time who were in a certain room in the ED, who all had open wounds, and contracted MRSA. Molecular techniques could be used to tell what type of MRSA the plaintiff contracted and whether it was an identical strain to the patient who was in the room before. This is a labor-intensive, costly, and farfetched scenario.

"There are so many things that you'd need to piece together that it never happens," Talan concludes. "It would be super difficult." ■

REFERENCE

1. Liang SY, Jansson DR, Hogan PG, et al. Emergency department environmental contamination with methicillin-resistant *Staphylococcus aureus* after care of colonized patients. *Ann Emerg Med* 2019;74:50-55.

Fall Injuries in the ED: A 'Hot Topic in the Medical-Legal Arena'

Falls are a "hot topic in the medical-legal arena," says **Charlene Pearman**, BSN, RN, LNC, a Charleston, SC-based legal nurse consultant. This includes the ED setting. "If a patient falls and sustains a serious injury or dies while being cared for in a healthcare setting, it's a really big deal. Medicare won't pay for it, for example," Pearman says.

Multiple organizations have released guidelines and recommendations on fall prevention.

"It is fodder for a plaintiff attorney. They can quote all of the strong language written by oversight organizations to strengthen their case," Pearman explains.

There are several questions that will become important in a case alleging ED nurses failed to prevent a patient's fall injury:

- Did the nurse assess for fall risk properly?
- Did the ED have a plan to prevent falls?
- Did providers implement the plan?
- Did leaders evaluate their process?
- Did providers follow policies and procedures?

"In the ED, it can be hard to show that the nurse worked through the nursing process because everything happens so fast," Pearman says.

Nonetheless, ED nurses need to ensure their documentation reflects all they did to prevent the fall.

"Find a way to show that you did your job," Pearman offers. As for hospitals, it is important that they maintain good policies and procedures regarding safety and falls, train nurses properly, and provide enough staffing for nurses to do their job safely. "If hospitals can show that, then they are going to have a much better chance at defending themselves," Pearman predicts. ■

COMING IN FUTURE MONTHS

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- Allegations against hospitals on negligent credentialing
- Successful malpractice claims involving anticoagulants
- How ED care becomes issue when hospitalized patient sues

Hospital Advertisements About ED Care Can Cause Problems for Defense

Hospitals try to set themselves apart from the competition with advertisements about the excellent care people can expect in their EDs. But beware: The ads can be used against hospitals by creative plaintiff attorneys in many ways. To prevent this, "ED staff should be empowered to speak up to hospital leadership if they notice false advertisement," says **Amy Zheng**, MD, a practicing EP at Southwest Healthcare System, and assistant clinical professor at the University of California, San Diego School of Medicine.

There are some examples of how marketing claims can complicate the defense of an ED malpractice claim:

• Hospital ads referring to "board-certified EPs" are problematic if any EP involved in the patient's care is not board-certified. "There are lots of scenarios where a particular EP isn't board-certified, even if most EPs in the department are," says Zheng. "EDs, especially in places with recruitment issues like rural areas, may be staffed by physicians from different specialties."

Patients may be seen by trauma surgeons or general surgeons who are board-certified in their own specialty, but not necessarily emergency medicine. Likewise, patients may see a single part-time or locum tenens EP who is not board-certified or a recent graduate who is board-eligible but not board-certified. Any of these scenarios can lead to allegations of false advertising.

• Hospitals may face vicarious liability for EPs' negligence due to the legal doctrine of apparent agency. It is not enough for hospitals to prove EPs were not hospital employees but independent contractors with their own professional liability insurance. Plaintiff attorneys argue that it is the patient's perception that matters.

"It is really getting kind of absurd, the lengths that some courts will go, to find the hospital liable in this kind of apparent agency argument," says **Michael R. Callahan**, JD, a senior attorney in the Health Care Practice Group at Katten Muchin Rosenman in Chicago. Hospital advertisements can become a pivotal factor. "In one case, the plaintiff argued that because EPs simply had a name tag with the hospital's name on it, she assumed they were hospital employees," Callahan recalls.

The defense team demonstrated all the steps taken to make it clear EPs were not employees of the hospital. This included informed consent forms and posted signs. "The court rejected this argument, and found the hospital responsible," Callahan says.[1]

Verbal explanations, signage, and forms sending the message that the ED group are independent contractors can refute apparent agency claims. Still, patients could insist they never saw the sign, rushed through the informed consent to get treatment, and had no idea what the "legalese" meant.

"Courts will also look to how the hospital 'holds itself out' to the public in terms of advertisement and promotion of its services, including the ED," Callahan notes. Print and social media can be used to refute the hospital's claim that ED personnel are not hospital employees.[2] Plaintiffs can find ads with statements welcoming new EPs to the hospital or picturing the ED. Plaintiff attorneys claim the patient assumed this meant the EPs were hospital employees. "The plaintiff attorney will look at whatever arguments they can make to connect the EP to the hospital, to somehow convince the court that the patient viewed the EP as a hospital employee," Callahan says.

Similarly, if the hospital's advertising promises a level of care that is not met by independent contractor physicians, that is problematic. It potentially raises the standard of care to which the hospital is held, explains **Matthew Zimmerman**, JD, a partner in Holland & Knight's West Palm Beach, FL, office. It is not just marketing or advertising that is at issue. "It's also internal manuals, handbooks, websites, and even the branding on scrubs or lab coats," Zimmerman adds.

• Advertisements can provide plaintiffs with additional causes of action, which often are easier to prove and carry longer statutes of limitations than traditional malpractice claims. These cases are highly fact-dependent, according to Zimmerman. "The jury would grapple on whether the advertisements rose to the level of representations, whether they were false, and whether they were material and the plaintiff relied upon them."

If so, and if the plaintiff's injuries were connected to or caused by the matter misrepresented, the plaintiff could pursue claims. These claims also may carry the ability to seek punitive or exemplary damages and attorneys' fees. "In states where damages caps are in place, plaintiffs may use these claims to try to avoid those limits," Zimmerman explains.

For a negligent misrepresentation claim, the plaintiff must establish that the defendant made a false

statement regarding a material fact, the defendant knew or should have known the representation was false, the defendant intended the representation to induce plaintiff to act on it, and the plaintiff sustained damages in justifiable reliance on the representation.

"If the plaintiff can show intent, the plaintiff can also assert fraud," says Zimmerman, adding that consumer protection and false advertising statutes provide additional potential claims. "The advertising must be material and make representations and not be mere 'puffery' or 'sales speak' that no consumer would reasonably rely upon."

• **Advertisements can create confusion about the standard of care.** If hospital ads mention wait times less than 30 minutes, and a patient waits longer, the advertisement can be used to suggest that hospital failed to meet its own standard of a 30-minute wait time. "Jurors may believe the advertised level of care is the standard," Zimmerman says. The same is true of claims such as "world-class emergency room care" or "a team of qualified doctors."

A Kentucky hospital's slogan, "You don't just deserve emergency care. You deserve remarkable care," resulted in deceptive marketing claims.[3] In Florida, a hospital was subject to a $178 million verdict from a botched bariatric surgery because, in part, the hospital marketed itself as a "Bariatric Center of Excellence" with an "experienced team."[4,5]

"The plaintiffs argued there was no team, and the physician working on the surgery was not sufficiently experienced," Zimmerman says.

Marketing should convey the experience of the average patient, with input from ED leadership. If EPs are not comfortable with the message, says Zimmerman, "the marketing should change." ■

REFERENCES

1. *Davis v. Ingalls Health System*, No. 1-17-1696 (Appellate Court of Illinois, First Judicial District, May 11, 2018).
2. *Yarbrough v. Northwestern Memorial Hospital*, No. 1-14-1585 (Appeal from the Circuit Court of Cook County, Illinois, Aug. 19, 2016).
3. Wolfson A. Patient sues Norton over ads and malpractice. *The Courier-Journal*, Aug. 18, 2014. Available at: http://bit.ly/2KUnCGe. Accessed July 1, 2019.
4. *Chandler v. North Florida Surgeons* (Florida Circuit Court, Jan. 23, 2012).
5. Broward C. Clay deputy awarded $178 million in lawsuit against Memorial Hospital. *The Florida Times-Union*, Jan. 23, 2012. Available at: http://bit.ly/2XyUjz5. Accessed July 1, 2019.

Just Apologizing Not Enough for EDs to Reduce Malpractice Risk

Simply apologizing is not enough to reduce malpractice liability risks, according to the authors of two recent studies.[1,2] "Based on the effect of the laws on both medical malpractice litigation outcomes and health-care outcomes, both papers concluded that apology laws have the opposite of their intended effect," says **Benjamin McMichael**, JD, PhD, lead author of both studies.

Apology laws enacted by 39 states and the District of Columbia make apologies inadmissible as evidence in subsequent malpractice trials. The laws are based on the assumption that patients who receive apologies will not be as likely to take legal action. Researchers analyzed claims from a national malpractice insurer over an eight-year period and concluded that apology laws are not doing what they purport.

"They can both increase measures of medical malpractice liability risk, such as claim size and claim frequency, and physician behavior associated with higher malpractice risk," says McMichael, an assistant professor of law at the University of Alabama. For instance, physicians in states with apology laws are more likely to practice defensive medicine.

Neither paper focused specifically on the ED. However, the results still are applicable to that setting. "I have no reason to suspect that apology laws would benefit these providers when they generate increases in the malpractice risk of other providers," McMichael offers. EPs should be aware that apology laws vary in how much protection they offer. "Generally, the content of the apology determines what is admissible," he says.

In states with "partial apology" laws, only statements of sympathy and condolence are inadmissible. In the small number of states with "full apology" laws, admissions of liability also are inadmissible. "Importantly, mistaking oneself for receiving the protection of a full apology law when only a partial apology law is in place is problematic," McMichael cautions.

A well-meaning EP might include an admission of liability as part of an

apology to a patient, believing all they say is protected. However, in a state with a partial apology law, the admission of liability would be admissible at trial. "States have generally been going toward more, not fewer, apology laws," McMichael notes, adding that courts have not weighed in on apology laws extensively. "Medical malpractice litigation rarely ends up in a procedural posture where a court would publish an opinion."

Only a few courts actually have addressed apology laws in published opinions, and they have all upheld them. "In fact, Ohio's Supreme Court arguably took what was a partial apology law and converted it into a full apology law," McMichael says.[3]

The study results do not undermine the existing evidence on apology and disclosure programs, says **Florence LeCraw**, MD, an adjunct professor in the Andrew Young School of Policy Studies at Georgia State University. Rather, the findings suggest that simply being allowed to apologize is not enough to reduce malpractice risk. "The bottom line is that the apology laws that most states enacted are counterproductive," LeCraw argues.

Apology laws are simply "no substitute" for effective Communication and Optimal Resolution (CANDOR) programs, according to LeCraw. CANDOR laws have been passed in Massachusetts, Oregon, Iowa, and Colorado. These laws permit privileged discussions between physicians and patients after medical errors and allow for compensation offers (where appropriate). Although any hospital can implement CANDOR, the laws make it easier to do so, LeCraw says.

Many people mistakenly think that apology laws and CANDOR laws are the same thing. "This has caused confusion," LeCraw notes. "CANDOR is not simply telling patients the truth. It is labor-intensive for the hospital and can require significant financial outlay."

This misconception came up when a bill was introduced to pass a CANDOR law in Colorado. An opponent incorrectly testified that the research on apology laws showed that a CANDOR law would worsen liability outcomes. Proponents of CANDOR stepped in to correct the record and offered a paper showing the benefits of CANDOR.[4]

The idea of CANDOR is growing steadily but slowly, says **Richard C. Boothman**, JD, owner and principal of Boothman Consulting Group, LLC. Boothman is former executive director for clinical safety/chief risk officer at the University of Michigan Health System. Before CANDOR was implemented at the University of Michigan, claims had hovered around 260 to 300 for many years. After implementation, despite higher volumes, claimed dropped to 80 to 90 per year.[5]

"Most continue to equate the CANDOR concept only with early resolution of threatened and actual claims alone," Boothman explains.

Savvy risk managers always have identified selected claims and attempted to avoid protracted and costly litigation. "That concept alone is not new. Yet, many who claim to be utilizing CANDOR are really only cherry-picking difficult claims to settle," Boothman says.

For instance, some hospitals will not talk to patients until they complain or refuse to broach the topic of compensation until a patient asks for money. "Those practices are not CANDOR. Instead, CANDOR is an aggressive approach that has at its heart a desire to create an accountable clinical culture that promotes continual clinical improvement," Boothman explains, noting that responding to patient injuries with honesty, transparency, and proactivity is an important piece. "But that's not what drives the model. Claims savings are not the primary motivation for CANDOR."

EPs often worry that CANDOR will get them into legal trouble, says **Timothy McDonald**, MD, JD, director of the Center for Open, Honest Communication at MedStar Institute for Quality and Safety Leadership. "For years, we've been told that when bad stuff happens, we shouldn't say anything. The whole delay, deny, and defend culture is still present in a lot of places," McDonald says.

The ED setting is ideal for CANDOR, which offers systemic approach to the response to unexpected harm, according to McDonald: "Almost everything that happens in the ED is unexpected. It's why people come to the ED instead of other places."

It is not easy to directly connect CANDOR to the absence of a lawsuit. "It's hard to say that because you did this, you avoid a lawsuit," McDonald explains. "But our data show that adopting this across the board, including the ED, will reduce claims and lawsuits."

In McDonald's experience, approximately 60% of claims and lawsuits "go away, with no indemnity payment, once you share the information." There are some challenges that are unique to the ED setting:

• The fact that ED providers have no pre-existing relationship at all with the patient or family. "What we do is identify who the really super communicators are, who can help in these circumstances," McDonald says.

• Lack of information on previous clinical encounters. "A lot of times in the ED, they're taking care of a patient who's had a ton of clinical care in the community. But they don't have the full picture," McDonald

says. This puts the EP in a tough position when answering questions on what exactly went wrong. They are doing so with minimal information on all the other care the patient received and also are concerned about throwing their colleagues under the bus. "There are lots of questions that come up that they are not able to answer," McDonald says.

Often, CANDOR in the ED is more difficult, Boothman acknowledges. There are times when patients who are injured because of their emergency care do not return. There is no continuing relationship with the patient.

"It is challenging sometimes to know if the care rendered in the emergency department was actually erroneous or unreasonable," Boothman laments.

Sometimes, a "misdiagnosis" can be an early presentation that evolved only after the patient left the ED. "Patients are seen only in only short vignettes of their lives, in brief ED visits. This offers emergency medicine physicians few second chances to get it right," Boothman says.

CANDOR relies on early identification of patient injuries and unintended clinical outcomes and the ability to reconnect with the patient. "In an emergency medicine setting, it becomes more challenging," Boothman says. Still, CANDOR is an effective approach when patients experience unintended clinical outcomes after ED care. "CANDOR can be a powerful model to clear the air and help everyone understand what happened and why," Boothman offers.

One ED patient presented early with generalized symptoms that later turned out to be a serious infection. "We found out about the case only after the patient presented elsewhere for care. That physician made some thoughtless remarks about how the early emergency physician 'missed the boat on this one,'" Boothman recalls.

The second EP never bothered to see the records or contact the first EP to find out what evidence was available at the time of the ED visit before making the disparaging remarks. It was only after the patient hired a lawyer that the matter finally was aired.

The providers met with the patient and his lawyer. As a group, they reviewed the early signs that were present when the patient presented to the ED. They explained why the diagnosis could not reasonably have been made at that time. Both the patient and his lawyer were satisfied with the explanation. Later, it was discovered that the patient sought out the EP at the second hospital and confronted him about the misleading statements. "I remember feeling that we should also have confronted that physician. But the doctors involved did not want to 'stir the pot,'" Boothman reports.

The group had established a constructive relationship with that patient's lawyer. "He knew we were approachable, that we would be brutally honest, and that if we had made a mistake, a lawsuit would not have been necessary," Boothman notes.

Such a rapport is one benefit of adopting a CANDOR approach consistently, instead of using it only for selective cases where lawsuits appear imminent. "You quickly establish a reputation for credibility and ethics. That goes a long way to preventing litigation," Boothman offers.

The patient's lawyer already knew he could call and request an honest meeting before filing a lawsuit. "Under the CANDOR approach, we were also known to defend vigorously if we did not treat someone unreasonably," Boothman notes.

If it were not for this mutual understanding, the EP might have found himself defending a groundless case caused by another physician's unfortunate comments.

"That credibility is a key component of the systematic consistency that arises from always being honest and following a principled approach," Boothman says. ■

REFERENCES

1. McMichael BJ, Van Horn RL, Viscusi WK. "Sorry" is never enough: How state apology laws fail to reduce medical malpractice liability risk. *Stanford Law Rev* 2019;71:341-409.
2. McMichael BJ. The failure of 'sorry': An empirical evaluation of apology laws, health care, and medical malpractice. *Lewis & Clark Law Review* 2018;22:1199.
3. Ohio Rev. Code Ann. §2317.43. Available at: http://bit.ly/2KTIld5. Accessed July 1, 2019.
4. LeCraw FR, Montanera D, Jackson JP. Changes in liability claims, costs, and resolution times following the introduction of a communication-and-resolution program in Tennessee. *J Patient Saf Risk Manag* 2018;23: 13-18.
5. Kachalia A, Sands K, Niel MV, et al. Effects of a communication-and-resolution program on hospitals' malpractice claims and costs. *Health Aff (Millwood)* 2018;37:1836-1844.

CME/CE OBJECTIVES

After completing this activity, participants will be able to:

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

ED LEGAL LETTER™

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CME/CE QUESTIONS

1. **Which is true regarding ED patients leaving against medical advice (AMA)?**
   a. Generally, courts require consultation with psychiatry to determine decision-making capacity of the AMA patient.
   b. The standard of care for capacity assessment is lower if substance abuse is involved.
   c. Documentation that the patient was alert and repeated instructions is more than sufficient to refute allegations that the patient lacked capacity.
   d. The determination of decision-making capacity comes down to the emergency physician's (EP) judgment, as opposed to any one single objective measure.

2. **Which is recommended to reduce legal risks of AMA patients?**
   a. Thoroughly document the fact that the EP found the patient to be frustrating and difficult.
   b. Warn patients that they will be financially responsible for the ED visit if they leave before the evaluation is complete.
   c. Arrange follow-up care only on the condition that the patient complete the ED evaluation.
   d. Document attempts to make a follow-up appointment, answer questions, or provide medications.

3. **Which is true regarding discoverability of ED quality assurance (QA) materials?**
   a. Patient names should be used in all email correspondence instead of modified medical record numbers.
   b. QA documents in the ED are not protected under the Patient Safety and Quality Improvement Act.
   c. Federal courts must recognize state peer review privilege when determining discoverability of peer review-protected information.
   d. Peer review documents in a federal EMTALA case may be discoverable.

4. **Which is true regarding hospital advertisements and other promotions about ED care?**
   a. References to "board-certified" EPs are not problematic as long as most EPs in the department are board certified.
   b. Advertisement-related claims can provide plaintiffs with additional arguments to support an apparent agency claim against a hospital.
   c. Informed consent forms stating EPs are independent contractors bar plaintiffs from making apparent agency claims.
   d. Hospitals cannot face vicarious liability for EPs' negligence merely because EPs might wear name tags with the hospital's name.