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INSIDE

RELIAS MEDIA

Most ED Med/Mal Claims Include Diagnostic Error; Many Result in Permanent Injuries, Death

About one-third of malpractice allegations in the ED resulted in permanent injuries. Of those cases, 38% involved grave injury or death, according to the authors of a recent analysis of 1,362 closed medical professional liability claims from 2014 to 2018.[1]

"That was probably the most surprising finding," says **Solveig Dittmann**, RN, BA, BSN, CPHRM, one of the report's co-authors and a senior risk specialist at Coverys, a Boston-based provider of medical professional liability insurance. Other key findings:

• The ED was the fourth-highest location to trigger claims (after surgery, physician offices, and inpatient units);

• Overall, 13% of all malpractice claims involved ED care;

• Cardiac or vascular illnesses were the most common conditions identified in ED claims (23%; followed by infection at 18%, neurologic at 8%, medication-related at 7%, fracture/dislocations at 7%, gastrointestinal-related conditions at 6%, and psychiatric conditions/suicide at 6%);

• Fifty-six percent of ED malpractice claims included allegations of diagnostic error.

"There is a real risk in the ED environment to not only to make an inaccurate diagnosis, but to have one result in the death of a patient," Dittmann says.

Sometimes, emergency physicians (EPs) discharge patients after ruling out only the most obvious possible cause of symptoms without probing further. Perhaps the best-known example is the actor John Ritter. He presented to an ED complaining of heartburn symptoms, but staff ruled out a cardiac event. "He ended up back in the ED with a dissecting thoracic aorta. They took him to surgery, but were unable to save him," Dittmann recalls.

To guard against misdiagnosing a life-threatening condition, Dittmann and colleagues recommended EDs

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use clinical decision support tools (e.g., practice guidelines for high-risk presentations). "These tools assist providers in addressing all the pertinent medical history and current symptoms to reach an accurate diagnosis," says Dittmann. The analysis revealed several more important findings:

• Of the diagnosis-related ED claims, 44% alleged some type of failure during the initial history and physical evaluation. "The reason the ED assessment is such a problem relates to the pace and pressure," Dittmann explains.

There is not always time for a good assessment. Some ED patients arrive unconscious with no one to provide a history and no previous medical records available. From there, Dittmann says EPs are "faced with a situation where you have to make diagnosis completely devoid of having a patient history."

• Many claims involved communication breakdowns of some sort. Not all EDs have an established way to hand off patients to the next shift. "If information isn't conveyed to the next provider, everything can fall apart," Dittmann cautions.

Some claims alleged no one was ever told of abnormal radiological or lab findings that came back after discharge. "Many EDs lack a defined process to ensure the information gets conveyed to the patient or the primary care physician," Dittmann says.

In one case, a patient presented to an ED with an infection. Blood culture results were not communicated, revealing that a different antibiotic was needed. That patient returned to the ED severely septic.

Other cases with a similar fact pattern involved X-ray overreads performed the following day. These showed a fracture that was not caught until after the patient left the ED. "There are numerous instances where the medical record shows the patient was never informed of a fracture," Dittmann laments.

The situation is far more serious if there is an initial negative reading of a CT of the brain, but the overread reveals an intracranial hemorrhage. Ideally, the radiologist providing the initial read has access to the complete medical record, including the patient's complaints, symptoms, and the nature of the injury. "It might affect his or her interpretation of the CT scan," Dittmann says.

Other claims involved incidental findings unrelated to the reason the patient came to the ED. In one case, a CT scan showed appendicitis, which required an immediate appendectomy. It also showed a kidney lesion, which the patient was not told about. "Three years later, a CT scan revealed renal cell cancer, which had been noted on the very first radiology report," Dittmann adds.

Good communication needs to happen if someone discovers incidental findings. According to Dittmann, one possible solution is a system in which all overread studies are sent to an inbox of a designated ED provider automatically. This provider should be someone who is in the department at the time the tests come back. "They are the ones responsible to ensure follow-up happens," Dittmann notes.

Another possible solution is to designate a full-time nurse or nurse practitioner (NP) whose specific role is to follow up on test results of discharged ED patients.

• Patients with frequent ED visits underwent a less-than-thorough evaluation. This can cloud

the ED provider's decision-making process.

"Bias sometimes interferes. Sometimes, providers have a preconceived notion about a particular patient," Dittmann explains.

EPs jump to a conclusion earlier than they should and do not perform a complete evaluation. One such case involved a 56-year-old woman with a severe anxiety disorder and multiple previous visits for shortness of breath and rapid pulse. She had been evaluated many times to rule out a heart attack. Each time, she was diagnosed with panic attacks, treated with lorazepam, and discharged.

"The last time she came in to the ED with the same symptoms, the department was very busy," Dittmann says. The EP briefly evaluated the patient, prescribed a sedative, and discharged her.

"Four hours later, she arrived via ambulance in full cardiac arrest and ultimately died of a massive myocardial infarction," Dittmann reports.

• NPs or physician assistants (PAs) diagnosed patients without consulting the supervising EP. "There really have to be guidelines in place for when those particular providers must consult with an EP on the diagnosis and plan of care," Dittmann says.

One jury returned a $5 million verdict for failure to order an arterial ultrasound in an ED patient who ultimately required amputation. In that case, the PA failed to order diagnostic testing to determine if a patient's diminished pulse was caused by a partial arterial blockage.

"The PA had a complex patient. He did consult the physician. But the physician, in this case, should have seen the patient before agreeing to the PA's plan of care," Dittmann offers.

• Thirty-six percent of claims involved medications, either the wrong drug or wrong dose. Forty-nine percent of all medication-related allegations involved antibiotics, opioids, or anticoagulants. One ED patient received an excessive dose of opioids, resulting in cardiac arrest; the patient required resuscitation.

In another episode, a patient with a pulmonary embolism received a dose of heparin that was too low, and later died of a blood clot in the lung. Still another patient with an arm wound was not prescribed antibiotics, ending up with a severe infection and permanent disability.

In other claims, the wrong medication was administered. Barcode scanning, says Dittmann, is "a really fabulous risk strategy, but one which is still not in all EDs." Not surprisingly, cost is the main obstacle to its implementation.

"But one major adverse medication error would be enough to justify the investment of that kind of safety technology," Dittmann argues.

If a medication error happens, it is important to know why. Did an ED nurse fail to barcode scan the medication order? Did a patient experience an adverse reaction because no one ever addressed medication reconciliation? "Use occurrence-reporting data to identify not only medications given in error but the reason behind the error," Dittmann suggests.

Some EDs employ a pharmacist whose sole responsibility is to provide medication reconciliation for ED patients. This is uncommon at community hospitals and critical access hospitals — and cost is not the only obstacle.

"There aren't that many pharmacists available in smaller communities," Dittmann observes.

• Some patients deteriorated after they were triaged as nonurgent initially. "The worst-case scenario is that not only does the patient wait several hours, but nobody notices that they deteriorated while waiting," Dittmann says.

One claim alleged negligent ED triage. In that case, a man's ECG performed during transport indicated a right bundle branch block and sinus tachycardia. Yet, the ED triage nurse deemed him "nonurgent." An hour later, the patient still had not been evaluated by an EP.

"The patient went into cardiac arrest, a code was called, but he was unable to be resuscitated," Dittmann says.

Dittmann says the best way to guard against this nightmarish scenario is to put the waiting area under direct observation by ED personnel, and to mandate a standard practice to check on patients every 15 minutes: "Triage is not a one-time thing; it's an ongoing process." ■

REFERENCE

1. Gibson T, Burke A, Dittmann S, Small M. Emergency department risks: Through the lens of liability claims. Coverys, June 24, 2019. Available at: http://bit.ly/2KhQtl5. Accessed Aug. 1, 2019.

COMING IN FUTURE MONTHS

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- EP's text can end up discoverable in lawsuits
- How plaintiff expert concludes ED malpractice occurred

Negligent Credentialing Puts Hospital on Hook in ED Claim

Negligent credentialing is a way to bring the hospital into malpractice litigation against an EP. It also circumvents state damage caps in some cases.

"Negligent credentialing gets around med/mal damages caps because they are tort actions against the hospital, not medical malpractice actions against the physician," explains **Nathan A. Kottkamp**, JD, a partner in the Richmond, VA, office of McGuireWoods.

Kottkamp has seen several allegations support a negligent credentialing cause of action in ED litigation, including failure to screen an EP's qualifications and background at the time of initial credentialing, failure to check the National Practitioner Data Bank (NPDB) for a history of problems, failure to check references, failure to confirm qualifications, and failure to perform appropriate diligence or peer review if concerns are raised about an EP's competence.

"The risk of negligent credentialing is very real," says Kottkamp, noting any of these issues can legally expose hospitals. "A plaintiff could use a collection of malpractice cases as the basis of an allegation that the hospital and its medical staff were not doing their job to monitor the quality of an EP's skills."

Hospital bylaws requiring physicians to report malpractice actions upon the filing of an action (not just if the case is settled or decided by a jury) can guard against this. "Hospitals should then independently investigate the matter to determine if corrective action is warranted," Kottkamp offers.

Hospitals are exposed to vicarious liability based on "negligent credentialing" if physicians or nurses known to be incompetent are allowed to treat patients, says **Dan Groszkruger**, principal of Solana Beach, CA-based rskmgmt.inc. "Proof of malpractice in a prior lawsuit may or may not constitute notice of incompetence that would justify punitive measures, such as discipline or dismissal," he notes.

The most common situation in which "negligent credentialing" translates to hospital liability? The EP or ED nurse failed to report previous malpractice, but the hospital finds out about it anyway. "'Bad' doctors might show up at a hospital on temporary locum tenens assignments," notes Groszkruger, adding that warnings circulated by hospital systems that operate facilities in several states can help prevent this. "If the hospital fails to take reasonable steps to discover the previous malpractice after being placed on notice, then the hospital may be found negligent."

Publicly available court and licensing agency records of malpractice judgments and settlements can be used to support a negative credentialing cause of action. "The assumption is that EPs who have been found negligent by a jury, or those who agreed to pay significant amounts of money to settle malpractice claims, are probably suboptimal performers," Groszkruger explains.

The rationale is that these EPs should be denied privileges. At the very least, they should be investigated more thoroughly than the standard applicant to ensure that they possess the necessary knowledge and skills. "Other indications of suboptimal performance are not available to the public," Groszkruger says. These include an EP's poor quality or outcome statistics and disciplinary actions arising from mistakes that harmed patients. Generally, these are confidential and privileged. If it was available to the plaintiff, says Groszkruger, "it would qualify as evidence supporting a negligent credentialing lawsuit."

It is difficult (but not impossible) for a hospital to argue it was unaware of an EP's troubling malpractice history. Conceivably, an EP who loses a license in one state could continue practicing in another.

"This is not easy, but individuals can change their names, falsify professional records, or even take steps to create a new identity," Groszkruger observes. This could allow an EP to apply for and obtain a professional license in another state, then apply for hospital privileges with authentic-appearing documentation. "If for some reason the hospital's routine checks are not able to detect fraud, privileges might be granted," Groszkruger says.

However, systems are in place to prevent this. "'Bad' clinicians are identified in some nationwide publications, designed to make it difficult or impossible to create a new identity and regain a professional license," Groszkruger explains.

The NPDB was created to protect the public from unscrupulous clinicians. The Joint Commission's performance standards for credentialing also are designed to identify fraudulent applications. One issue is that staff assigned to check credentials normally work in the hospital's medical staff office. "Staffing may be inadequate or subject to chronic turnover," Groszkruger notes. Frequency of surveys is another

concern. If a hospital is out of compliance with credential checks as required by The Joint Commission, says Groszkruger, "the failures may not be discovered until the next three-year survey." ■

Anticoagulant Misadventures Give Rise to Malpractice Claims

An unconscious man arrives at an ED after a serious accident. A family member tells a nurse that he takes an anticoagulant, but the information never makes it into the patient's chart. The providers do not restart anticoagulants in the hospital, and the patient suffers a stroke and dies. The family successfully sues for malpractice.

This is a common fact pattern in claims involving improper management of a patient's anticoagulation medications in the ED, says **Ashley Dobbin Calkins**, Esq., an attorney in the Richmond, VA office of Hancock Daniel. Such cases "can result in catastrophic injuries to the patient and large verdicts or malpractice settlements and board investigations for the healthcare providers," she warns.

Calkins has seen certain allegations in ED malpractice claims involving anticoagulants, including improper administration, improper withholding, and failure to continue the drug during hospitalization. To defend these lawsuits successfully, "solid documentation on the patient's home medications, last medication dose, medical history, and symptoms is essential," Calkins observes.

The process starts with information the ED triage nurse or emergency responder gathers. It extends to every other provider who comes in contact with the patient, Calkins says. "Increasingly, audit trails are being examined in discovery if there is any question about *when* entries were made in the chart," Calkins explains.

If a patient experiences a serious bleed in the ED, it becomes important when the information about at-home medications was entered into the electronic medical record (EMR) and available to the EP. "Signing off on charting as soon as possible and closing an entry is the best way to keep EMR records clean and reliable," Calkins says.

Timely EMR charting "also ensures other providers have access to key information as decisions about anticoagulant administration are made throughout a patient's hospitalization," Calkins adds. Boarded patients in the ED might need anticoagulants while waiting for an inpatient bed to become available.

"EPs are not responsible for writing inpatient orders, but somebody needs to know to continue them, because otherwise it's a problem," says **W. Frank Peacock**, MD, FACEP, FACC, FESC, vice chair of research for emergency medicine at Baylor College of Medicine in Houston.

The inpatient physician is responsible for the admitted patient being boarded in the ED. "Geography doesn't absolve them of their responsibility," Peacock says. Nonetheless, it is more difficult for the inpatient providers to care for the boarded ED patients and, therefore, more legally risky.

"All the checks and balances are upstairs," Peacock explains. "The more you get out of the routine, the more opportunity there is for misadventure."

There are some other issues that can land EDs in legal hot water:

• The ED provider stops anticoagulants inappropriately. When a patient with atrial fibrillation comes in with a scraped knee, an EP might stop the anticoagulants. If the patient then suffers a stroke, the EP could be held liable, Peacock offers.

• The patient presents with a clear indication for anticoagulants, but no one administers the medication. "If the patient has clear indications and you don't administer, it's the same as if you have clear indications and you stop it," Peacock warns. An example would be a patient with new onset atrial fibrillation, which goes away during the ED visit. The patient is discharged without anticoagulants; later, he suffers a stroke. The EP who failed to administer the drug could be held liable, Peacock says.

Sometimes, ED patients are taken off warfarin, even *with* clear indications, because the drug carries significant risks. "Warfarin is a pretty rough drug. About 0.7% of patients on warfarin will suffer an intracranial hemorrhage, of whom 50% will die," Peacock notes. Newer oral anticoagulants carry a lower risk for complications or death. "The pressure to get patients off of them is less. Our practice is changing, and guidelines are having to catch up," Peacock adds.

Historically, patients were taken off warfarin with any type of bleeding injury at all. Now, EPs balance the risk of a fall with the risk of bleeding and dying, according to Peacock. "EPs should use the CHA_2DS_2-VASc score to evaluate stroke risk," he says. If the patient scores a 4 on that scale,

there is approximately a 4% risk of stroke in the next year.

"That's a pretty high risk of having a stroke, and having a stroke is way worse than having a broken leg," Peacock says. "But the reality is patients with high scores should be on anticoagulants" in the absence of clear contraindications.

• No one knows the patient is taking anticoagulants. "If there is a reason a normal history cannot be obtained, the chart should reflect the issue," Calkins says.

If the patient cannot provide a reliable medication history, identifying family members with information "can be essential to determine proper treatment," she adds.

• The EP fails to obtain a CT scan. "Diagnosing intracranial hemorrhage is not very difficult," Peacock says. Patients are profoundly symptomatic, and it is quite visible on the CT.

"The trick is making sure to get the CT scan for any patient with symptoms consistent with an intracranial hemorrhage or head trauma on anticoagulants," Peacock adds.

• EPs fail to administer reversal agents — or fail to explain why they did not. "Reversal agents are now available, in some fashion, for all the anticoagulants," Peacock notes. "But there is a fair amount of subjective judgment required for the appropriate administration."

Some, such as fresh frozen plasma (the reversal agent for warfarin), can lead to complications. Others are costly; for example, andexanet alfa costs in the range of $50,000 for some reversals. "You may get pushback from your hospital," Peacock says. "But it's going to be really hard to defend a case when the patient comes to the ED and dies and there's an antidote you didn't use."

Statements from defense experts on why the antidote would not have changed the bad outcome anyway are likely to fall on deaf ears. "In patients with a small hemorrhage, it will be very difficult to explain why you didn't treat aggressively," Peacock cautions. Futile cases also can be legally problematic. If a patient experiences a massive intracranial hemorrhage, and registers a Glasgow coma scale score of less than 8, and they are barely responsive, "you can give them the antidote but it won't change anything," Peacock says. "At some point it's futile. Documenting your belief of why it's futile is probably pretty smart."

Family members still may contact an attorney, believing the antidote could have saved the patient. "Putting down documentation of why you did what you did is one way of preventing a lawsuit," Peacock advises. "It would also be good to have a neurosurgical opinion documented."

A plaintiff attorney might allege that an expensive antidote was not offered because the patient was uninsured, a minority, or homeless. "They may say *'Had it been a wealthy suburbanite, you would have done something different,'"* Peacock offers, adding that good documentation on the futility of the situation "can guard against allegations that decision-making was based on bias, costs, or ability to pay instead of medical necessity." ■

Multiple Defendants in ED Claim? Often, Conflicts Are Inevitable

Many ED malpractice claims include multiple defendants. Each defendant has unique (and sometimes competing) interests.

"Coordination of claims defense efforts in these cases is key," says **Marc E. Levsky**, MD, a board member of the Walnut Creek, CA-based The Mutual Risk Retention Group and an EP at Marin General Hospital in Greenbrae, CA.

"It's very difficult to consistently make a united front. We just try to keep a lid on it," says **James B. Edwards**, JD, a Stafford, TX-based medical malpractice defense attorney. The defense team's first step is to determine where the liability primarily lies. "We ask, is this a doctor case or is this a hospital case?" Edwards says. "It has to be looked at carefully and from the beginning,"

If a conflict comes up during litigation, one of the defendants could be put at a disadvantage because he or she hires a new attorney late in the game. "The risk is that one defendant will have to be spun off to a new lawyer who has not been involved from the beginning," Edwards says.

Sometimes, it is apparent right away that the interests of the EP and the hospital are at odds. "It's usually fairly easy to identify cases where you can't represent both parties just by reading the plaintiff pleadings," Edwards notes.

Edwards represents EPs and hospitals together, but only in cases where their interests are truly congruent. "Those are usually cases where nobody did anything wrong

and there are no known conflicts of interest," he reports.

The plaintiff attorney may bring a strong case against the EP and a weak case against the hospital. The hospital is kept in the case as a deep pocket, particularly if potential damages are in the millions. "Most EPs in Texas only carry $200,000 in limits," Edwards says. "It's the EP who is the legitimate defendant, but the last thing the plaintiff attorney wants is to get a big judgment they can't collect on."

In some states, the defendant can enter into a high-low agreement. This might benefit the EP, but not the hospital. "If that's the case, then they usually need to have separate lawyers representing the separate parties," Edwards advises.

Multiple ED defendants sometimes share the same malpractice insurance provider. Even if they are not criticizing one another's care, separate counsel may be needed. "When the entities providing malpractice insurance for co-defendants are different, separate counsel will almost always be involved," explains **Melanie Heniff**, MD, FACEP, FAAP, assistant professor of clinical emergency medicine at Indiana University School of Medicine and a JD candidate at Indiana University's Robert H. McKinney School of Law.

Attorneys representing the hospital *and* the EP are obligated to defend the interest of both parties. "If they don't, it actually puts the lawyer and the insurance company at risk," Edwards cautions. If the lawyer did something that is good for the insurance company but harmful to the client, both the lawyer and the insurance company can be held liable, he explains.

Regardless, some EPs hire personal counsel at their own expense. Typically, these attorneys have no right to participate in the litigation. Their role is to observe matters and serve as a private advisor to the EP. "This way, the EP is getting advice from somebody they know doesn't have any connection at all from the insurance company," Edwards says.

This becomes important if the EP wants to defend the case, but the insurance company wants a quick settlement. "It happens all the time. The lawyer has to promote the interests of the insured, who wants to defend the case," says **Matthew P. Keris**, JD, a shareholder in the Moosic, PA, office of Marshall Dennehey. Assuming there is no consent-to-settle clause, the insurance company makes the final call. All the defense attorney can do is advocate for the EP's position.

"There is very little, though, that we can do to make the insurance company do what the doctor wants," Keris says.

Outside counsel can be more aggressive. "Threats may need to be made. *'You better settle this case, or my client will go to another hospital,'*" Keris says. The outside counsel also can argue that the insurance company is acting in bad faith by refusing to settle a case within the policy limits. A threatened lawsuit in the event of a verdict in excess of the policy limits can be an effective tactic.

The situation is coming up more often since most insurance policies lack consent to settle clauses. This takes the choice out of the EP's hands. "The insurance company can do whatever they want, really," Keris adds.

Attorneys must consider each defendant's role independently to determine potential conflicts, according to Heniff. The timing of care, the role each defendant played in the patient's care, and the information and resources available to each all come into play. "Defending one's own care does *not* usually need to involve being critical of co-defendants," Heniff notes.

Waivers of conflicts can allow attorneys to continue representing multiple defendants in a claim. This gives all parties a full disclosure of how potential conflicts could affect their interests. This works sometimes, even if their interests are not completely aligned. "But sometimes there are conflicts that you just can't get around," Keris cautions. "I've been in situations where people have different version of events, and each is blaming the other."

Attorneys may need to represent one defendant and ask someone else to represent the other defendant. Ideally, this happens *before* privileged communication takes place.

"Otherwise, the attorney has confidential information from one client that goes against another client's interest," observes Keris, adding that continued representation of both defendants is no longer possible. "You have to be very vigilant in making sure there are no conflicts before you dive deep in the case. As soon as you get a whiff of a conflict, you want to insulate both parties."

An ED nurse's statement that the EP co-defendant caused the patient's bad outcome could become a pivotal part of the nurse's defense. The attorney could continue representing the nurse, but someone else would have to represent the EP.

"If the ED nurse's only defense was that the EP screwed up, you can't represent both parties in that scenario," Keris explains.

If both parties already shared privileged information, "you now have to bow out for both parties. The attorney has to get out completely," Keris adds. Two new attorneys have

to be assigned to the case. In an ideal world, this is a situation that is avoided, since the two new lawyers have to get up to speed on the case and perform duplicative work. "It doesn't happen that often, but sometimes it does," Keris says. "The timing of the privilege disclosures determines if you can stay in the case." ■

EPs Facing Litigation Need Support

An EP starts a shift, only to find a certified envelope containing a letter of intent to sue in the department mailbox. There is growing awareness of the toll malpractice lawsuits takes on EPs who suddenly find themselves defendants.

"It's well-known that being involved in litigation has a significant emotional and sometimes physical effect on providers," says **Gary W. Tamkin**, MD, FACEP, vice president of provider development at VEP Healthcare, a Concord, CA-based ED and hospitalist staffing company.

Tamkin has consulted with many EPs who were sued for malpractice. They suffered from a wide range of ailments, including depression, anxiety, self-doubt, sleeplessness, and strained relationships. "It can even lead a physician to early retirement or even worse, suicide," says Tamkin, associate clinical professor of emergency medicine at University of California San Francisco School of Medicine.

Self-care is the key to surviving litigation, according to Tamkin. Ideally, this begins long before the notice of intent to sue arrives. "To have that armor on you each day puts you in a better position to deal with this successfully," Tamkin offers. "It's so important to address burnout every day. You can't predict when one of these events will hit."

Tamkin says self-care is a "risk mitigation tool" as well since EPs are more likely to experience cognitive errors if they are burned out. "To realize that if you practice long enough a lawsuit is almost inevitable can be very self-preserving," Tamkin adds. "It's not personal; it's just a part of doing business."

EPs are used to making fast decisions in life-or-death situations. "Malpractice litigation is not, in the words of an ED provider, a 'quick disposition.' Lawsuits are a part of your life for months or years on end," Tamkin observes.

The fact that juries and judges may not understand the medical issues at hand is especially difficult for EP defendants. "A jury might see something that has gone terribly wrong for a patient and wants to see them get something to help them through the situation, possibly regardless of whether the EP actually played a role in the outcome," Tamkin explains.

Even if the standard of care was clearly met, juries have been known to return a verdict in favor of the plaintiff anyway. Some feel sympathy for the injured plaintiff without considering how the verdict will affect the EP defendant. "They may not see it as the EP's money," Tamkin notes. "They might view the aid as coming from insurance companies, who they don't typically have much regard for."

A recent paper on self-care of EPs addressed life-changing stress, including malpractice litigation.[1] "Being named in a lawsuit is very stressful," says **Steven Selbst**, MD, a study co-author, EP at Nemours/Alfred I. duPont Hospital for Children in Wilmington, DE, and professor of pediatrics at the Sidney Kimmel Medical College of Thomas Jefferson University in Philadelphia.

Many EPs who find themselves defendants question their own skills and experience anger and depression. "Some get to the point where they leave medicine altogether," Selbst laments. "Some have a significant psychiatric response to it and need professional help."

Selbst says the same could be said for EPs involved in a medical error

that harms a patient. Some hospitals have developed support teams for physicians in this circumstance to be sure they are coping well.

"There is so much emphasis now on physician wellness," Selbst observes. "The whole country has recognized that the burnout rate and the suicide rate are much higher than the general population."

Involvement in an error or malpractice lawsuit are known contributing factors. "Hospitals are recognizing that you have to worry about the medical staff and their well-being," says Selbst, noting that defense attorneys can be a major source of support for EP defendants. "Hopefully, they are looking out for the well-being of the physician as they are going through this terrible ordeal, which lasts for a very long time."

The first thing defendants are told is to not talk to anyone about the case. It is important to note that this pertains only to the details of the lawsuit, not the physician's emotional reaction to it.

"You can talk to your spouse, friends, and family about how you are feeling," Selbst says. "If you are really not coping well, you can talk to a professional." ■

REFERENCE

1. Mull CC, Thompson AD, Selbst SM, et al. A call to restore your calling: Self-care of the emergency physician in the face of life-changing stress-Part 1 of 6. *Pediatr Emerg Care* 2019;35:319-322.

ED Patient 'Drunk, Disheveled, Foul-Smelling,' According to Medical Record

The following statement was documented by an obviously frustrated EP, one who failed to realize the medical/legal implications of what he was charting: *"This drunk, disheveled, foul-smelling patient shows up yet again demanding narcotics and being generally obnoxious."*

"If the patient has an untoward event in the ED or after discharge, statements like this in the medical record render the chart indefensible," cautions **John Shufeldt**, MD, JD, MBA, FACEP, principal of Scottsdale, AZ-based Shufeldt Consulting.

Inappropriate comments about patients are surprisingly common in ED charts. One EP charted, *"This morbidly obese, drug-seeking indigent showed up again today demanding narcotics."* Another documented, *"Given the patient's profound stupidity, one wonders how he has survived this long."*

Documenting the patient's exact words is a better way to tell the story, according to Shufeldt. The EP should document *"Patient states, 'I drank a 12-pack, then started to have abdominal pain'"* instead of *"Intoxicated patient is complaining of abdominal pain."*

Other ED charts included statements depicting ED nurses as incompetent. Some comments were specific on the timing of events during ED visits, which can bolster allegations that care was delayed. One EP charted, *"The patient waited for over an hour before the nurse saw fit to answer the call light."* EMR time-stamping already makes the timing of events clear without the insulting remarks. "The order is timed, and the medication or treatment is timed," Shufeldt notes. "That speaks for itself."

Another EP charted, *"But for the nurse's gross stupidity, the patient would be alive today."*

"My mantra is, *'Never fight battles in the medical record,'"* Shufeldt offers. "Finger-pointing always ultimately gets the finger pointed back toward you."

Inappropriate documentation is used first to embarrass the provider at the deposition, then (if the case goes to trial) in front of a jury. "Basically, it impugns the provider," Shufeldt adds.

Other statements target consultants or other physicians. One ED medical record included this statement: *"Unfortunately, due to the anesthesiologist's incompetence, the patient died during the procedure."* Another angry EP wrote, *"I repeatedly told Dr. X not to send the child home."*

"These statements can be used to bring a physician into the case, and they can be used to hang the physician," Shufeldt warns.

Sticking to the facts is less risky legally and expresses the same point. For instance, an EP might be frustrated that a consultant refuses to come in to evaluate the ED patient. That EP might chart: *"I called Dr. Cardiologist at 10:00, 10:15, 10:20. She returned my calls at 11:00. She advised. ..."*

The bottom line is that factual statements, or words stated by others in quotations, are better than judgmental ones.

"Angry charting never works in the best interest of the provider," Shufeldt

says. "Physicians should avoid it at all cost."

Christopher B. Colwell, MD, often sees angry charting in ED medical records. This always complicates the defense.

"I have seen some outright horrendous statements written that are demeaning to patients," says Colwell, chief of emergency medicine at Zuckerberg San Francisco General Hospital and Trauma Center.

One EP charted, *"The patient is an entitled dirt bag who doesn't deserve to be here."* Another charted, *"The patient is an obnoxious drunk who comes in once again complaining of chest pain."*

Charting while angry is dangerous for the EP, according to Colwell. The EP writes things he or she may regret later, which then become part of the ED medical record. Instead, Colwell says to "document in a descriptive way that tells a story that can only have one ending: the one you determined was most appropriate under the circumstances you were faced with."

Regardless of how frustrating a particular case is, documentation should convey the EP's calm, thoughtful decision-making. "That is going to help the defense of any future malpractice claim," Colwell adds. ■

'Very Scary' Legal Ramifications for Hospitals if ED Clinician Diverts Drugs

If ED nurses or physicians are diverting drugs, a state board investigation, malpractice lawsuit, or both are possible. Further, the hospital is legally exposed, says **Allan Tobias**, MD, JD, "if they were told about it and did nothing, or if they should have known about it by their internal procedures." Hospital administrators typically testify, *"We acted as soon as we found out."*

"This, of course, says nothing about how they *should* have known, by their own policies and procedures, that should have alerted them," says Tobias, a Walnut Creek, CA-based healthcare consultant and lawyer. If a plaintiff attorney can prove the EP defendant was impaired and medical malpractice can be proven, "this will never see a courtroom," Tobias adds.

Such a case would settle out of court quickly as it would be impossible to defend. The plaintiff attorney will explore whether there was a history of impairment and whether anyone else saw the EP diverting or using drugs. "But there still must be medical malpractice proven the usual way," Tobias notes.

Kimberly New, JD, BSN, RN, a partner at Diversion Specialists, a Knoxville, TN-based consulting firm that specializes in the prevention, detection, and response to drug diversion by healthcare personnel, says these factors leave a hospital exposed legally:

- Not putting appropriate controls in place;
- Prior similar diversion and no remedial action;
- Patients not receiving appropriate pain control;
- Patients exposed to bloodborne pathogens due to the ED provider's tampering with injectables;
- Data that reflected diversion was happening, yet no one did anything about it.

The fact the ED provider is not a hospital employee does not protect the hospital. "If the ED provider is a credentialed provider, the hospital can still face potential liability," New cautions.

Hospitals leaders can expect to be asked these questions at depositions:

- What are you doing to detect diversion?
- What are your policies regarding diversion prevention?
- Are staff following these policies?
- How long did it take to respond to the diversion event after suspicion was raised? Why did it take so long?
- How many diversion cases are identified each year?
- What are the details of recent cases?
- What type of pre-employment screening is conducted?

Even if the diverting individual is an EMS provider who is not affiliated with the hospital, the hospital still may be legally exposed if there was gross negligence in preventing diversion. "The reaction of hospitals varies," New observes. "They often say they are doing their best and that the diversion couldn't be prevented."

Since direct care providers typically use the drugs they are stealing, patients could be harmed as a result. "If the provider is impaired and provides negligent care, the diversion issue could and probably would arise in the litigation," New predicts.

Plaintiff attorneys can prove a bad outcome happened because of an impaired ED nurse or physician in several ways. If doses that were ordered can be proven to have been diverted, the patient usually can show unrelieved pain. Negligent care due to impairment also might be proven.

"There have recently been a number of reported ED diversion cases on point," New adds.

Some hospitals seemed to do surprisingly little to prevent diversion. "There have been instances where people had dispensing mechanisms in isolated areas that were close to bathrooms, making it easy to conceal diversion," says **R. Stephen Stigall**, JD, an attorney in the Cherry Hill, NJ, office of Ballard Spahr.

If an ED nurse is fired for drug diversion, and a prospective employer calls for a reference, hospitals often withhold the information. This is largely due to concerns about patient privacy regulation. The hospital says the employee was terminated but will not elaborate further; Stigall says there is nothing wrong with a matter-of-fact response such as, *"The employee was diverting drugs."*

"There is a culture of silence to some degree. But if an employee is caught, I would not be silent about it," says Stigall, cautioning that the fired employee could sue the hospital for defamation. "Those suits, because truth is an absolute defense, could be dismissed rather easily."

Still, a civil lawsuit could be the least of a hospital's problems when it comes to drug diversion.

"Criminally, the hospital itself can get into hot water with the Department of Justice [DOJ]. That is what should have the rapt attention of general counsel at hospitals," Stigall underscores.

In 2017, the DOJ announced a resurgence and vigilance in prosecuting those involved in the opioid trade. Of particular interest to hospital leadership, says Stigall, is the responsible corporate officer doctrine. This says that even if higher-ups do not know about subordinates' illegal activity (such as drug diversion), the leaders still can be held criminally liable for failure to impose appropriate safeguards to prevent it.

"That is very scary if you carry it to its logical conclusion," says Stigall, who offers this scenario: An ED nurse is going to the automated medication dispenser and pulling fentanyl or oxycodone pills, diverting these instead of giving them to the intended patient. The DEA comes to the hospital for an onsite inspection and discovers that the ED nurse has been diverting pills.

"They would probably charge the nurse. But they could also hold the hospital, or the people involved in the direct chain of command over the nurse, criminally liable — if it's a significant enough case," says Stigall, noting that some cases have involved thousands of diverted pills. Some recent examples:

In 2014, a health system agreed to pay a $1.55 million fine to resolve a criminal investigation involving the diversion of more than 20,000 oxycodone pills because its compliance procedures and controls failed to detect and prevent the diversion.

In 2015, a hospital agreed to pay $2.3 million to resolve a criminal investigation in which a DEA audit revealed that more than 20,000 pills had been diverted and an investigation revealed that two nurses were responsible for the diversion of at least 16,000 oxycodone pills.

On Nov. 8, 2017, the DOJ charged a nurse with accessing secured automatic dispensing machines and removing hydromorphone from vials intended for patients, replacing the solution with a saline solution. "If convicted, the nurse faces four years' imprisonment and a $250,000 fine," Stigall reports.

Several recent prosecutions have involved the responsible corporate officer doctrine. "One made it all the way to the Supreme Court, which declined to review the case, leaving the responsible corporate officer doctrine intact," Stigall says.[1]

What should hospital leaders do if drug diversion is discovered? One possibility is to immediately bring it to the attention of the DOJ.

"The hope is that the hospital gains credit for cooperating and, therefore, doesn't get tagged for criminal liability," Stigall offers.

Showing that the hospital discovered the diversion on its own and turned it over to the state "would be a very good defense," Stigall says. "The catch-22 is that the DOJ may say, *'Thank you very much. Now, here's a criminal indictment for failure to supervise.'"*

Several company executives have been charged with violations of the Controlled Substances Act. "I don't think it will be a far stretch before we start to see this used more frequently for the hospital setting," Stigall predicts.

Stigall says the only good response, to avoid liability under the responsible corporate officer doctrine, is to truthfully state: *"This was beyond our control."*

"That's probably your only defense," Stigall says. Some hospitals implement checks and compliance based on the DOJ's own guidance.[2] "If it happens, you can point to those and say, *'We did everything we possibly could, and yet the person got away with it,'"* Stigall says. ■

REFERENCES

1. *United States v. DeCoster*, No. 15-1890 (8th Cir. 2016).
2. U.S. Department of Justice, Criminal Division, Fraud Section. Evaluation of Corporate Compliance Programs. Updated April 2019. Available at: http://bit.ly/2SZ4CY8. Accessed Aug. 1, 2019.

ED LEGAL LETTER™

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CME/CE QUESTIONS

1. **What did the authors of a recent analysis of closed ED claims recommend?**
   a. Using clinical decision support tools
   b. Directing radiologists to conduct the initial read before accessing the complete medical record to avoid bias
   c. Eliminating barcode scanning for most nonurgent patients
   d. Reassessing patients in waiting areas less frequently except for those with cardiac and vascular symptoms

2. **Which is true regarding negligent credentialing?**
   a. Hospital bylaws should require that physicians must report only those malpractice actions resulting in a verdict or settlement.
   b. Warnings circulated by multistate hospital systems are one way to identify malpractice that went unreported by an emergency physician (EP).
   c. Different reporting standards for malpractice history should apply to "locum tenens" EPs.
   d. Proof of compliance with The Joint Commission requirements shields hospitals from exposure to negligent credentialing claims.

3. **Which is true regarding conflicts between co-defendants in ED malpractice claims?**
   a. If a conflict comes up during litigation, one of the parties could be put at a disadvantage because they hire a new attorney.
   b. Generally, conflicts between the EP and hospital are impossible to identify before discovery has been completed.
   c. Outside counsel retained by EPs have the right to participate in the litigation, but defense attorneys must handle negotiations on whether the case should be settled or defended.
   d. EPs have the right to decide whether a case will be settled or defended on their behalf, regardless of whether the policy includes a consent to settle clause.