ED LEGAL LETTER™

THE ESSENTIAL RESOURCE FOR EMERGENCY MEDICINE MALPRACTICE PREVENTION AND RISK MANAGEMENT

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INSIDE



# Emergency Medicine Residency Programs Devote Little Time to Malpractice Education

Only 18% of emergency medicine (EM) residency programs offer more than four hours a year of medical malpractice/risk management education, according to the authors of a recent study.[1]

"The lack of significant dedicated time devoted to malpractice/risk management was surprising, given its importance in day-to-day clinical practice," says **Jason J. Lewis**, MD, the study's lead author and an emergency physician (EP) at Beth Israel Deaconess Medical Center in Boston.

Researchers surveyed 91 program directors on methods used to teach residents about diagnostic errors, quality assurance (QA), and malpractice/risk management. "There has been an increased focus on preventing diagnostic error. In order to decrease this type of error, it is imperative that we start by educating our trainees," Lewis says.

Researchers recommended EM programs implement a more formalized curricular structure and use a multimodal approach with didactic lectures, actual cases reviewed by malpractice attorneys, and simulation cases. "This may prove beneficial in residency education and for patient safety and quality initiatives," Lewis predicts.

Malpractice litigation takes a severe toll on EP defendants, regardless of the outcome. "Once a med/mal suit is triggered, regardless of outcome or who 'wins,' the process itself is long, tiresome, and stressful," says **Bryan E. Baskin**, DO, FACEP, associate quality improvement officer at the Cleveland Clinic's Emergency Services Institute and an attending EP at Cleveland Clinic Fairview Hospital.

The role of patient satisfaction is a common blind spot. "Many suits are driven out of anger and dissatisfaction, more than actual outcomes," Baskin observes.

In considering their legal exposure, ED providers sometimes focus narrowly on complaints viewed as high risk, such

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**AUTHOR:** Stacey Kusterbeck
**EDITOR:** Jonathan Springston
**EDITOR:** Jill Drachenberg
**EDITORIAL GROUP MANAGER:** Leslie Coplin
**ACCREDITATIONS MANAGER:** Amy M. Johnson, MSN, RN, CPN

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as chest pain. In reality, says Baskin, "malpractice risk exists on every case in EM. At times, a fast-track case such as a laceration can be just as risky as the chest pain patient, though the indemnity is different."

For example, wounds and fractures account for a significant percentage of lawsuits against EPs. "Another example would be back pain, which has lower volume but a high indemnity in EM malpractice due to poor outcomes," Baskin offers.

A good understanding of the medical malpractice process is important, since it clarifies why litigation occurs in the first place. EPs can gain this kind of expertise by seeking out mentors who specialize in risk management, or by participating in formal presentations, Baskin says.

Knowing how documentation affects things is particularly important. "Often, key points of EM charts are lacking, simply because providers were not aware of why the documentation is warranted," Baskin explains.

For instance, some EPs do not understand the malpractice implications of documenting risk factors in chest pain patients. The same is true for why it is important to chart a thorough neurological examination in someone presenting with headache.

"Educating providers on important aspects of general EM charts, as well as certain aspects of high-risk EM chief complaints, are equally important to quality patient outcomes as well as risk mitigation," Baskin adds.

Identifying and discussing high-risk areas for malpractice is important for the entire ED team — nurses, physicians, physician assistants, nurse practitioners, or any other professional working with the patient, says **Mark F. Olivier**, MD, FACEP, FAAFP, risk manager medical advisor at Lafayette, LA-based Schumacher Clinical Partners.

The frequency of "failure to diagnose" allegations in ED closed claims signals the need for some education on common cognitive errors, such as premature closure and anchoring. "Education of providers would make them aware of these potential pitfalls, and thereby prevent them in the future," Olivier says.

Communication breakdowns, such as ineffective handoffs, also are common in ED malpractice lawsuits. "Teaching effective provider communication is a [technique] to decrease the possibility of malpractice claims," Olivier says.

It is important for everyone to know why lawsuits still can occur even if the ED patient received excellent care. Often, it is because the ED chart does not make it clear enough that the standard of care was met.

"Appropriate documentation may be the deciding factor whether a plaintiff attorney takes a claim or not," Olivier observes. There are a few items that, if well-documented, could make successful litigation against the EP less likely:

• **Documentation that addresses any significant historical and/or physical exam discrepancies between providers.** "Not addressing an issue documented by a nurse, which later turns out to be a serious medical problem, could be difficult to defend," Olivier cautions.

For example, an adolescent complains of abdominal pain and testicular pain to the nurse. However, the patient only mentions the abdominal pain when talking to the EP.

"If only the abdominal pain is addressed, without a genital examination, and the patient ends up with testicular torsion, this could be a problem," Olivier warns. Likewise,

ED providers sometimes overlook pertinent EMS findings. "This could provide ammunition for the plaintiff attorney," Olivier adds.

• **Evidence that appropriate discharge instructions were given to the patient, summarizing the diagnosis, treatment plan, and follow-up process.** Also important, says Olivier: "Provide enough information to allow the patient to recognize a problem if their condition worsens, and seek care promptly."

• **A reasonable explanation for why a patient is dispositioned with an abnormal vital sign.** Olivier offers this example: A patient with an infection believed to be benign and appropriate for outpatient treatment has a persistent minor tachycardia at the time of discharge, which cannot be explained by fever.

In this kind of case, Olivier says the EP should re-evaluate the patient to make sure a more serious infection is not overlooked. Also, if records show the patient had tachycardia previously, this should be documented at the time of discharge.

• **Evidence that a discussion took place with the patient about any incidental findings noted on imaging unrelated to the patient's clinical presentation.** "The discussion should be documented in the chart, and recommendations documented in the discharge instructions," Olivier says.

• **A summary of any conversations with consultants or admitting providers, including what was discussed and the management plan.** "Documenting *time* of consultation is especially important when managing time-dependent illnesses, which the plaintiff attorney may allege was not managed in a timely fashion," Olivier explains.

• **Medical decision-making that includes an adequate differential diagnosis for the patient's presentation and how the EP arrived at the final clinical impression.**

• **Documentation of reassessments after treatment, showing how the patient responded.** Evidence of improvement is especially important in a patient discharged home after a prolonged ED stay. If, for example, a patient with intractable vomiting and abdominal pain is given antiemetics and hydrated over several hours, improvement in vital signs should be charted.

"Serial abdominal examinations should show no evidence of development of a surgical abdomen during this treatment period," says Olivier, noting that an oral hydration trial should be considered to show improvement. "You want to try and make a record of the patient's improving condition over time." ■

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# It Was Too Early to Detect Sepsis: Can Defense Team Prove It?

Sepsis is not always diagnosable, or even present, at the time of an ED visit. All testing performed in the ED may provide negative results. Despite these facts, plaintiffs still may prevail in a missed sepsis lawsuit.

"In my experience, plaintiffs' attorneys often focus on the small details of a patient's vital signs," says **Scott Martin**, JD, a partner at Husch Blackwell in Kansas City, MO.

If any assessment whatsoever is abnormal, even slightly, plaintiff attorneys generally claim that it indicated a preseptic or septic condition, which required further testing and treatment. In some missed sepsis cases, even the *definition* of fever became a key issue.

"The simple question of 'What is a fever?' does not have a universally accepted numerical definition among patients or medical staff," Martin explains.

If lab work is *not* ordered for a patient with an elevated temperature, Martin recommends charting the reasoning behind the decision. Sometimes, temperatures documented in the ED chart are hotly debated by both sides. "Some plaintiffs' attorneys will literally spend hours focusing on differences of 0.1 or 0.2 degrees and whether antipyretics may have affected the readings," Martin observes.

Typically, plaintiffs look for abnormal vital signs (fever, hypotension, tachycardia), abnormal lab results (white blood cell elevation), changes in mentation, and/or pallor, says **Daniel LaLonde**, MD, associate medical director of the ED at Ascension Providence Hospital in Southfield, MI. "The plaintiff attorney may also look for subtle exam findings such as a decubitus ulcer or descriptors like foul odor, oozing, swelling, redness, or warmth," LaLonde observes. There are two helpful pieces of documentation.

First, the EP should explain why he or she does not think it is sepsis, or why sepsis fell further down the list of differential diagnoses. "Sepsis can be a moving target," LaLonde notes. "It's very possible that the patient presents to the ED very early on its progression."

Second, the EP should document that the patient and family were informed of warning signs of sepsis and when to return to the ED. "Your medical decision-making should also include a reassessment of the patient prior to discharge," says LaLonde, adding that statements such as "patient has no other complaints" or "patient feeling better" can be helpful. "It would be very difficult for a patient who has fulminant sepsis to be, in fact, feeling improved without any other complaint."

**Barbara Brasher**, RN, CLNC, a legal nurse consultant at Flemington, NJ-based Med League, sees these issues come up frequently in missed sepsis claims:

- **There is documentation that a patient was confused, lethargic, or tachycardic, yet the temperature was taken orally instead of rectally.** "That gives the plaintiff the ability to argue that the initial vital signs were not done properly," Brasher says.
- **Nurses failed to start antibiotics or an IV fluid bolus in a timely fashion.**
- **EPs obtained a consult but did not follow the recommendations, such as an infectious disease specialist recommending repeating blood cultures.**
- **Documented recommendations of various providers conflict.** "A cardiologist wants the patient on fluid restrictions, but another physician orders a 1,500 fluid bolus," Brasher says.
- **Delays occurred because nurses could not access an IV, failed to find an external jugular vein, or failed to start an intraosseous or central line in a timely fashion.**
- **EPs claimed they were unaware of abnormal vital signs or the patient's worsening condition.** "As nurses, we can't assume that they're aware of a lactate that came back elevated just because we documented it," Brasher notes. "It's our responsibility to verbally let the emergency physician know."

When reviewing ED charts, Brasher pays close attention to any documentation that nurses free-texted. "That's important, because they're saying the drop-downs are not giving a true impression of the patient's situation," she says. Sometimes, ED nurses document statements such as "Notified physician of low blood pressure."

"Sometimes, that can be a red flag that something isn't going right," Brasher cautions. ■

# Study: 1 in 5 EMTALA Settlements Involves Psychiatric Emergencies

One in five settlements related to EMTALA violations involved psychiatric emergencies, according to a recent analysis of 230 EMTALA-related civil monetary penalty settlements from 2002 to 2018.[1]

"Prior work by our group had shown that about one in six EMTALA violations were related to psychiatric emergencies," says **Sophie Terp**, MD, the study's lead author.[2]

Several large, heavily publicized EMTALA-related settlements related to psychiatric emergencies were the impetus for the second study. "We decided to systematically evaluate characteristics of EMTALA-related civil monetary penalty settlements related to psychiatric emergencies, and how these differed from settlements not involving psychiatric emergencies," says Terp, an assistant professor of clinical emergency medicine at Keck School of Medicine at University of Southern California. Some key findings:

- The average settlement for psychiatric-related penalties was $85,488 vs. $32,004 for non-psychiatric-related cases;
- Five of the six largest settlements were related to cases of psychiatric emergencies;
- The three largest settlements all involved psychiatric emergencies;
- Failure to provide an appropriate medical screening exam (MSE) was cited in more than 80% of settlements involving psychiatric emergencies.

"Many providers are simply unaware of requirements with regard to psychiatric patients," Terp says.

Some hospitals were cited because patients presented to the ED with a psychiatric issue and were directed to a facility with psychiatric services that took their insurance, with no MSE documented. According to Terp, in several cases, a person with a behavioral health issue arrived at an ED in the custody of law enforcement, became disruptive, and was transported to prison at the direction of the ED provider — but no MSE was recorded.

Other commonly cited deficiencies involved failure to provide stabilizing treatment (68%) or arrange appropriate transfer (30%). Failure

to provide stabilizing treatment was more common among cases involving psychiatric emergencies (68% vs. 51%).

In some cases, patients came to EDs with psychiatric history, complaints, or behaviors, along with concurrent medical emergencies. These patients were not stabilized before discharge or transfer to an inpatient psychic facility. One such case involved a patient who was hypotensive with arrhythmia after suicide attempts. The patient was transferred to an inpatient psychiatric unit with limited medical capabilities, then was transported to another hospital for medical care. "Another hospital was cited for failure to stabilize a psychiatric patient who was allowed to elope in blizzard conditions in a hospital gown," Terp reports.

Terp says she was surprised by some CMS determinations made in one case. In response to media reports of psychiatric patients boarding for up to 38 days in an ED, CMS launched an EMTALA investigation at a hospital in the Southeast.

After reviewing hospital records, investigators identified 36 EMTALA violations. The hospital subsequently entered into a $1.2 million civil monetary penalty settlement agreement with the Office of Inspector General. The hospital was cited for not directing on-call psychiatrists to participate in MSEs and for not providing daily stabilizing treatment for patients on involuntary holds in the ED.

"Perhaps most surprisingly, the hospital was cited for failing to utilize available beds in their inpatient behavioral health unit to stabilize patients boarding in the ED on involuntary holds," Terp says. By policy and practice, the inpatient behavioral health unit had accepted only voluntary admissions for many years.

According to Terp, this case highlights the need for hospitals with inpatient behavioral health units to re-evaluate exclusions to their admission policies. This is especially important if there are available inpatient beds and affiliated EDs are boarding patients with psychiatric emergencies.

**Todd B. Taylor**, MD, FACEP, a Phoenix-based EMTALA compliance consultant, says, "This was a complex case in which CMS was apparently trying to make a point with regard to boarding psychiatric patients."

As for what EDs should do, Taylor says it is "the same thing they would do if they had more heart attack cases than they had resources for."

Solutions differ, depending on many factors. "But you cannot just ignore the situation, which is what many hospitals do when it comes to psych boarding," Taylor laments.

Considering the study's findings, Terp says hospitals should educate all ED providers and staff on these EMTALA requirements as they pertain to patients with psychiatric issues:

• **EMTALA applies to psychiatric emergencies.** Therefore, any patient presenting to a facility with a dedicated ED requesting evaluation is entitled to a MSE (and/or, if indicated, a psychiatric screening exam) to evaluate for the presence or absence of a psychiatric emergency.

• **Many psychiatric evaluation areas and OB triage units are considered dedicated EDs.** "Anyone staffing these areas should be aware of EMTALA requirements for patients presenting with medical and psychiatric complaints," Terp says. This may include psychiatrists, obstetricians, advanced practice providers, nurses, and other providers.

• **On-call mental health specialists should be involved in the care of patients deemed to have psychiatric emergencies while they are boarding in dedicated EDs.** Hospitals should consider policies requiring daily evaluation of psychiatric patients boarding in the ED for stabilizing treatment, Terp advises. Ideally, this should take place until admission or appropriate transfer can be arranged (or until the patient is deemed stable for discharge).

Once it is determined the patient requires inpatient care, it is usually prudent to involve specialists to manage the ongoing care just like any other illness, Taylor says. "But what if your hospital does not have any psych services, and there is no readily available place to send them?" he asks. "Now, you have to get creative."

Psychiatric care in the ED is "arguably the most difficult challenge for emergency medicine from an administrative perspective," Taylor argues.

One reason is the lack of inpatient services, especially for adolescents. The result is that patients in need of inpatient psychiatric care often are stranded in EDs for days or even weeks awaiting an available bed. "Most EDs are ill-equipped to manage ongoing acute mental health," Taylor adds. "Patients languish, receiving subpar treatment or no real treatment at all."

There often is no suitable space and no psychiatric specialists. "All of this has not been lost on CMS, which has taken an increasingly aggressive approach in an attempt to assure patients in this situation receive appropriate care," Taylor says.

There are a few reasons why hospitals land in trouble with EMTALA, including the fact that defining what constitutes a psychiatric

emergency medical condition "is difficult and often subjective," Taylor notes.

Providers do not always consider mental health as a "medical condition," even though a reading of EMTALA shows "it clearly is," according to Taylor. Exacerbating the issue: Some psychiatric hospitals often attempt to skirt EMTALA obligations by sequestering beds, thus limiting capacity.

Some mental health patients cannot cooperate with the required elements of an EMTALA transfer. On a related note, psychiatric specialists often do not understand or cooperate with on-call EMTALA duties and are reticent to manage patients held in the ED.

"Mental health patients require an inordinate amount of resources and time, two commodities lacking in the ED," Taylor notes.

Taylor says EDs need to develop policies, procedures, and resources to ensure EMTALA compliance for mental health patients while working with the local mental health community to ensure adequate follow-up.

"A lack of good community resources often leads to ED overutilization," he says.

Further, Taylor says EDs should address mental health emergencies with the same vigor as trauma, cardiac, and stroke episodes. "It is as deadly, and fraught with more liability," he cautions. ■

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# Consults, Studies Recommended By Others Carry Med/Mal Implications for EPs

Somewhere in the ED chart, somebody recommends involvement of a particular specialist, or that a specific study should be conducted. When this kind of recommendation is documented but never acted on, it can mean legal trouble for the EP.

"This is a really common problem," says **John Burton**, MD, chair of the Carilion Clinic's department of emergency medicine in Roanoke, VA.

There are two common scenarios where this arises during litigation:

**• Hospitalists and other consultants who round on ED patients recommend involving other specialties in the patient's care.** Hospitalists are used to handling consults on admitted patients. "It's very common for them to routinely involve a lot of other specialists during the course of a patient's multiday care," observes Burton, adding that hospitalists apply that same mindset to the ED. "The problem is the ED is not an inpatient unit. We don't have three days. We are very disposition-focused, and the clock is ticking."

The EP is under pressure from the patient and the system to make decisions in the moment that matter at that point in time. "That means we're picking and choosing which tests to order and which consultants to involve," Burton notes.

In contrast, hospitalists are used to an environment where they have multiple days to collect as many consultations as they believe are needed. In that setting, says Burton, "utilization of resources is not as consequential."

The problem is that during litigation, plaintiffs can point to the fact that another provider believed strongly enough that a specialist should be involved to document it in the chart. "Hospitalists' documented recommendations sometimes cannot be reasonably achieved in the ED environment," Burton laments.

**• Radiology reports frequently include recommendations for additional studies.** This is in part due to more claims naming radiology, Burton says. "That's causing them to put in more detailed recommendations. They feel like they need to spread their risk a little bit."

The burden of acting on the radiology recommendations falls on the EP who ordered the test.

"As long as there are no credibility issues around the quality of their interpretation, the radiologists are pretty much free and clear," Burton says.

If a bad outcome happens, and the EP ignored the recommendation to collect another consult or study, "this becomes a tremendous opportunity for the defense," Burton says.

For instance, a typical radiologist report might state: "Plain film of the knee demonstrates an effusion and soft tissue swelling. An MRI of the knee would give further clarification." The plaintiff can argue that the standard of care required the EP

to obtain the MRI that radiology recommended.

**Leonard Berlin**, MD, FACR, has never seen a radiology report include a recommendation that asks a certain type of specialist to evaluate the patient.

"I have not seen, and am opposed to, reports in which the interpreting radiologist suggests that the patient should be sent to a specific physician-specialist. If it happens, it's certainly beyond what a radiologist should do," says Berlin, a professor of radiology at Rush University and the University of Illinois, both in Chicago, and author of *Malpractice Issues in Radiology*.

However, radiologists often suggest conducting an additional study. A patient may undergo an X-ray of the spine to rule out a slipped disk, and the radiologist sees something questionable on the kidney. The radiology report notes, appropriately, that a CT scan or MRI should be considered. "But to say a renal surgeon should be consulted, that's just nonsense," Berlin argues.

If the ordering EP does not act on a radiology recommendation for an additional study, it could cause legal problems for the EP. "It's a question of how it's phrased," Berlin explains.

The report should use language such as "An MRI should be *considered* for further evaluation."

"Those are nice, innocent words. On the other hand, if the report says an MRI should be *done*, that is too strong," Berlin cautions. It should be clear to anyone reading the report that the radiologist is only making a suggestion. "We are not here to tell physicians what to do. We are here to make suggestions for additional studies to the best of our ability," Berlin stresses.

Occasionally, an attorney defending a radiologist contacts Berlin. The plaintiff may be claiming that the bad outcome happened because the radiologist failed to recommend an additional study. Another issue that sometimes arises during litigation involves verbal discussions between the ordering EP and radiologist about a certain patient. These informal conversations often go undocumented.

"The problem is, if it's not written down and then later something bad happens, they are going to disagree about what they said to each other," Berlin says.

Both the EP and radiologist should chart what was said. "If the emergency physician and radiologist want to discuss the case, why not? But when they walk away, they should make a note so there's no question about what somebody allegedly said," Berlin recommends.

Faced with a documented recommendation for consults or studies that may or may not be appropriate, the EP confronts a tricky risk management challenge. "You have to carefully choose how to approach that documentation, just in case there are any untoward events in the future," Burton says.

Some verbal communication should happen before anything is documented in the first place. For instance, a radiologist might say to the EP: "I think this patient has a maxillary sinus fracture and probably needs to see a maxillofacial surgeon." The EP might note that none are available in the hospital and that, in fact, there is only one plastic surgeon in the community available to see such patients. The radiologist could then document a more realistic recommendation.

It also gives the EP a chance to clarify whether the consultant believes the test or consult should be conducted emergently. "This might change the notes entered in the future," Burton offers.

Consultants should become accustomed to calling the EP before they put that kind of recommendation in the chart. "Optimally, there would be some verbal dialogue first to compare perspectives on it. But certainly, radiologists don't have time to make all those calls," Burton acknowledges.

Likewise, when a consultant comes to the ED to see a patient, that consultant would give the EP a quick verbal impression immediately afterward. This allows for some back-and-forth if the consultant is planning to document something that is wildly unrealistic or that the EP believes is inappropriate for the patient. "It only takes a few seconds. But in many circumstances, they are too busy to do it, so the consultant writes out the note without discussing it first," Burton says.

Sometimes, the note ends up full of recommendations for various consults that never happen. "That can get the emergency physician into trouble downstream," Burton warns.

EPs will not always agree with someone else's suggestion to involve a consultant in their patient's care. They do not always have time to document their reasoning for why a certain recommendation, in their clinical judgment, is not appropriate. "It's problematic for the EP because they are trying to get dispositions and decisions made," Burton explains.

EPs may believe the consult is not necessary at all or is of limited use to their patient at that moment. If the EP chooses not to collect a consult that clearly was recommended, says Burton, "EPs really need to contemplate the consequences."

Some EPs, fearful of liability, blindly follow the recommendations. This can lead to unnecessary care and wasted resources. A more reasonable approach, according to Burton, is to independently choose when to

involve consultants based on clinical judgment.

"If the consult is not emergent, the EP could take a middle ground by including the recommendation in discharge instructions," Burton explains. The patient would be instructed to obtain the consult on an outpatient basis in a reasonable amount of time.

An example would be a pulmonary nodule noted on a radiology report for a CT scan ordered to rule out pulmonary embolism.

"There should be a system in place to inform the patient," Burton says. "But there is no reason to consult a pulmonologist immediately to come see the patient."

It also is reasonable for EPs to document the lack of an emergent nature of a recommended consult. For instance, maxillary fractures and most orbital fractures do not require a specialist to come in immediately to see the patient in the department.

"These patients can be taken care of in follow-up, with notification to the specialist receiving the referral depending upon local practice preferences," Burton says. ED documentation should include a note that the patient was referred for specialist consultation on an outpatient basis, considering the lack of emergent management indication.

Further, note that a phone consultation was made with the specialist, with a visual or verbal description of the findings. Also, indicate that the consultant agreed this was a non-emergent case that could be managed on an outpatient basis.

For instance, someone might recommend referral to an orthopedist given a suspicion for a ligamentous injury of the knee or shoulder. In this case, says Burton, "the emergency physician will then document that this was made as an outpatient referral with documentation of an intact neurovascular examination and no indication for an emergent consultation."

Overly specific documentation on why someone is *not* obtaining a particular recommended consult could make the EP appear overly defensive. "In hindsight, it appears as though it was an obvious decision you should have made," Burton warns. "We see this around procedures."

An ED chart might read, "I don't think the patient needs a lumbar puncture because they don't have a fever and there is no vomiting." Years later, when the EP is named in a lawsuit alleging that a lumbar puncture should have been performed, the charting looks suspicious.

"You look at the record and say, 'Why didn't the EP just do the lumbar puncture?' It seems as though they were trying to talk themselves out of doing something they knew they needed to do," Burton says.

On the other hand, failing to mention the recommended consult also can backfire. It may look as though the EP never even considered the consult that did not happen. "Unfortunately, there is no hard and fast rule on how to reduce risks," Burton says. "EPs need to treat each scenario independently, and proceed with caution." ■

# Venting to Colleague About Med/Mal Case Can Trigger Subpoena

One of the first things EP defendants learn from their attorneys is to not discuss the claim with anyone. However, this is not realistic.

"The blanket statement that a defendant EP should discuss an active lawsuit with no one other than defense counsel requires some unpacking," says **Keith C. Volpi**, JD, an attorney at Polsinelli in Kansas City, MO.

The reason for this common mandate is that any statement a defendant EP makes to anyone other than defense counsel regarding an active lawsuit is discoverable and can be used against the defendant at trial. "Procedurally, any such statement commonly comes to light when an honest EP answers an interrogatory or deposition question along the lines of 'With whom have you discussed this lawsuit?'" Volpi explains.

A curious plaintiff then subpoenas for deposition anyone who is identified, looking to find out what was said about the lawsuit. "It's important to look at this from two perspectives: the defendant EP and the non-party EP," Volpi recommends.

The defendant EP may be working with the defense counsel for the first time. Thus, says Volpi, "there's little relationship and trust established early on," Also, it is likely the EP wants clinical input that an attorney simply cannot provide.

Volpi says it is unrealistic to expect a defendant EP to discuss an active lawsuit with no one — and that it would not be believable. "A defendant EP who doesn't discuss an active lawsuit with his spouse or business partner is difficult to present as human," Volpi argues.

A more realistic instruction might be: "Don't tell anyone anything about an active lawsuit that you wouldn't

want the jury to hear." A defendant EP should never admit liability, disparage the plaintiff or patient, or assign blame to a co-defendant in the presence of anyone but defense counsel, according to Volpi.

One defendant EP told her medical partner (a non-party EP) that the defendant EP had a rough night the night before she cared for the plaintiff; in hindsight, she "should have taken the day off rather than try to rebound and treat patients."

"I learned this before the non-party EP was deposed and it caused us to pay more in settlement than we otherwise would have," Volpi recalls.

As for a colleague who is not named in the lawsuit, Volpi says to remember that serving as a sounding board for the defendant could mean receiving a deposition subpoena. "If a non-party EP finds himself hearing things about a lawsuit that he knows the defendant EP would not want a jury to hear, the non-party EP should shut down the conversation," Volpi stresses.

If a non-party EP ends up subpoenaed, he or she "should tell the truth above all else," Volpi says. It may seem honorable to attempt to cover for a defendant EP, but perjury can drastically affect a non-party EP's license and career.

"The subpoenaed non-party EP should hire an attorney to determine if the subpoena can be quashed," Volpi says. The most common grounds for quashing a subpoena are procedural shortcomings in the preparation and service of the subpoena. Less commonly, a subpoena can be quashed if the subpoenaed EP can demonstrate the subpoena is a significant burden that would dramatically affect his or her practice (e.g., the deposition is scheduled during a time when he or she cannot take time off).

If not, it is best to deliver the truth in the light most favorable to the defendant EP. "The non-party EP should testify that the defendant EP 'voiced regret for plaintiff's poor outcome' rather than 'He told me that he really screwed up and was expecting this lawsuit,'" Volpi adds.

**Amy Evans**, JD, says there are two main triggers for a deposition notice or subpoena: If the ED provider's name appears in the medical record and/or if the person's name is mentioned by any party or witness to the case.

"Attorneys will question the ED provider about all aspects of the discussion," says Evans, executive vice president of the liability claims division at Bellevue, WA-based Intercare Insurance Services. They will cover the time, place, setting, witnesses, participants, what prompted the discussion, what was said, what they thought, and what they did thereafter. "It can become a bad case of 'telephone,' especially when memories and testimony differ as time passes," Evans says.

This can create "poor optics, and increase the value and exposure in a case," Evans adds. That is true even if the discussion had no bearing on the medical care provided.

"Attorneys will also attempt to use the ED provider as a de facto expert witness in the case," Evans explains. ED providers will be asked their medical opinions, what they would have done, and what should have been done. The attorney will ask these questions regarding both the facts of the case at hand and various hypothetical situations.

"The ED provider may also be asked their opinions about the defendants in the case, their professional and personal reputations, any rumors about them, and any knowledge of bad outcomes or complaints," Evans says.

Evans says the safest bet for EP defendants is to vent about the lawsuit only with their retained attorney. All such discussions are protected by privilege. EPs also should discuss the spousal privilege in their state with the attorney to ensure that those discussions are protected, too. "Therapy or counseling is also an option, which should provide privilege as well," Evans adds. ■

# Plaintiff Expert Looks for 'Smoking Gun,' But Often Finds No Evidence of Malpractice

Often, plaintiff experts are viewed as people who are out to get the EP. In reality, most of the time they find no evidence of malpractice.

"When a plaintiff attorney hires an expert to review the case, the expert often finds that there was no negligence," says **Ken Zafren**, MD, FAAEM, FACEP, clinical professor of emergency medicine at Stanford (CA) University Medical Center.

Good documentation counters allegations that the standard of care was not met. In this way, says Zafren, "the plaintiff's expert can save a treating physician from an unnecessary lawsuit." The process starts when the plaintiff attorney contacts the expert and gives a brief description of the case. The plaintiff checks to see if the expert has any conflicts, such as knowing any of the parties in the case. Zafren turned down one case because he knew the medical director of

the EMS service sued. "Most experts will not take a local plaintiff's case," adds Zafren, who says he will not take a plaintiff's case in Alaska or northern California because he works at referral hospitals in both places.

Next, the expert sends the attorney a CV and fee schedule. Once the expert is retained, the attorney sends the expert the medical records and any other relevant documents.

"In some cases, the material may be limited," Zafren says. In one case, an attorney retained an emergency cardiology expert, but sent only the one ECG at issue in the case. This way, the expert would not be biased about the ultimate diagnosis.

Some plaintiff's experts try to limit the materials sent to the expert to save money by curbing the time the expert spends reviewing the case.

"I have also seen a few instances of experts receiving incomplete materials in order to bias them by suppressing materials not favorable to the attorney's theory of the case," Zafren reports.

Most reputable experts insist on receiving all the relevant records and documents. "There are often many additional records, such as photographs that are not part of the medical record and policies and procedures of the hospital," Zafren notes.

From there, the expert reviews the records and discusses the case with the attorney.

"The expert does not write a report unless requested to do so by the attorney," says Zafren, adding that in most states, a report is discoverable (but the phone conversation with the attorney is not). "Usually, if the expert writes a report, the expert reads the draft to the attorney on the phone and edits the draft in consultation with the attorney."

Since drafts are discoverable, the expert usually writes the report in a Word file, modifies it in consultation with the attorney, and saves the final revision as a PDF.

"That way, there are no drafts except the final version of the Word file," Zafren says.

Usually, expert reviews are sought shortly after a plaintiff's attorney accepts a case.

"There is typically a conversation with the expert in which the lawyer or paralegal describes the basic facts of the case," says **Laura Pimentel**, MD, a clinical associate professor in the department of emergency medicine at University of Maryland School of Medicine.

Experts receive a huge volume of information. Much of it is repetitive: pages of lab results or other documents of minimal relevance to the ED visit. "I prioritize review of the ED visit or visits, including physician notes and orders, nursing notes, consultant notes, labs, ECGs, and imaging studies," Pimentel reports.

Next, she creates a timeline of the ED care. Any discharge instructions given to the patient are reviewed closely. "If the patient was admitted, the hospital course must be carefully reviewed," Pimentel says.

Any outpatient visits around the time of the ED visit also are important to review. "Experts should systematically review the care to render an opinion on whether or not the standard of care was met," Pimentel says.

Questions experts need to answer include (but are not limited to):

- Was there timely recognition of the clinical situation?
- Were appropriate diagnostic tests ordered in a timely fashion?
- Was there appropriate monitoring of the patient including timely recognition of deterioration?
- Were proper consultations initiated in a timely fashion?
- Was medical decision-making and reassessment thoroughly documented?

If the expert believes the standard of care was met, the attorney may decide right away not to pursue the case. Sometimes, the attorney asks another expert for an opinion. "This is common if specialty services are a prominent part of the case," Pimentel observes.

If Zafren's opinion is there was a bad outcome despite adequate (or even stellar) care, he informs the attorney. "That usually ends the case. Attorneys are seldom surprised when I tell them that even though the outcome was bad, the care was good," Zafren says.

Some cases are not so black and white. Frequently, attorneys identify multiple areas where they suspect care might have been substandard, delay in diagnosis or improper treatment among them. "Once we have gone through all of these, if there was no negligence, most attorneys won't file a case," Zafren says. "They have no desire to expend time and considerable money to bring a case they can't win."

To file a medical malpractice lawsuit, plaintiffs must show that an expert physician was consulted to substantiate the allegations, says **Anna Berent**, JD, claims counsel for Houston-based Western Litigation.

## COMING IN FUTURE MONTHS

- Legal risks if overdose patient leaves against medical advice
- Successful defense of ED claims alleging missed stroke
- How damage caps are affecting ED malpractice claims
- Legal interests of hospital and ED group may conflict

States like New York require a simple verification from plaintiff's counsel called "certificate of merit."

"It does not require that plaintiff's counsel reveal the expert's name specialty or what types of criticism said expert had," Berent notes.

However, other states are far more stringent. Some require an affidavit from the expert along with the notice to commence a medical malpractice action. This affidavit must contain the expert's name and specialty, which should be in the same field as the named defendant physician. For example, a radiologist cannot provide an affidavit with opinions on what an EP may have done incorrectly.

"Naturally, in states where disclosure of expert identity and opinions is not required, plaintiff's attorneys tend to go to generalist physicians for nonspecific discussions," Berent says.

Most plaintiff physician experts are diligent in their reviews, viewing the task as an interesting side job. "However, there are definitely a number of hired guns and go-to's that plaintiff firms use," Berent says.

For instance, in obstetrics/birth injury cases of catastrophic damages but dubious liability, defense lawyers have come to expect to see one of a handful of pediatric neurology and general obstetrician experts who typically testify in such cases. "The extent and the depth of a plaintiff's expert's initial review of the case often depends on the questions posed to them," Berent says.

Thus, the caliber of plaintiff's counsel's experience in the field of medical malpractice matters a great deal. "Given the contingency fee-based arrangement for medical malpractice cases, it behooves plaintiff's attorneys to have parity in expert specialty to the defendant's specialty," Berent says. It is in both the attorney's and the patient's best interest for the expert to play devil's advocate to ensure the case is meritorious. "Occasionally, where appropriate, plaintiff's counsel can seek a blind review of the case," Berent says.

This approach is used frequently by both sides in radiology cases. Berent has found blind reviews helpful in many ED cases.

"It eliminates any potential of Monday morning quarterbacking, since the expert does not know the outcome, ultimate diagnosis, or damages." ■

## CME/CE QUESTIONS

1. **Which did the authors of a recent study find regarding malpractice education offered by emergency medicine residency programs?**
   a. Fewer than 20% offered more than four hours of education a year on this topic.
   b. Residency programs are over-relying on didactic lectures.
   c. Reviewing actual cases was far less effective than simulated cases.
   d. Too much time is spent discussing lower-risk ED cases.

2. **Which can help defend against missed sepsis claims?**
   a. Evidence that the patient's temperature was only slightly elevated.
   b. Documentation showing the patient is feeling better and reports no additional complaints.
   c. The fact that no lab work was ordered for a patient with an elevated temperature, since it indicates sepsis was not a concern at the time of the visit.
   d. The fact that sepsis was not in the EP's differential.

3. **Which is recommended to avoid EMTALA violations involving psychiatric emergencies?**
   a. Hospitals should discontinue asking on-call psychiatric services to help with medical screening exams.
   b. Only ED providers should be stabilizing psychiatric patients boarded in the ED.
   c. Hospitals with inpatient behavioral health units should re-evaluate exclusions to their admission policies.
   d. Hospitals should not consider psychiatric evaluation areas or OB triage units as dedicated EDs under EMTALA.

4. **EPs can reduce risks of documented recommendations for additional consults or studies by:**
   a. arguing that the burden of acting on the recommendations fell solely on the consultant and not the EP.
   b. asking radiologists to more explicitly document recommendations for involvement of other specialties.
   c. requiring radiologists to use vague terminology such as "should be considered."
   d. documenting any discussions on particular patients, even if informal.

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