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ED Discussions after Patient Death Not Covered by Peer Review Privilege

Ohio court compelled resident to answer questions about ED conversations about care of patient who died shortly after discharge

*By **Michelle Bitterman Fish, JD** and **Robert A. Bitterman, MD, JD, FACEP,** Contributing Editor*

Jason Rinehart presented to the emergency department (ED) of Akron General Medical Center with nausea, vomiting, and back pain.[1] No definitive diagnosis was made, and the patient was discharged with medications to control his symptoms. He died hours after discharge, and an autopsy revealed an aortic dissection as the cause of death. The patient's father, Mr. Giusti, sued the hospital and treating physicians for negligent diagnosis and treatment of his son.

The resident involved in the care of the patient was Dr. William Kurtz. A couple of days after the patient's death, Dr. Kurtz received a phone call from someone in the ED asking him to come speak with the chairman of the ED, Dr. Daniel Schelble.

The issue at this stage of the case was whether the subsequent conversation between the resident and the ED chairman was privileged, i.e., protected from discovery via deposition and from use at trial by the state of Ohio's peer review protection statute.[1,2]

The following exchange occurred during the plaintiff's deposition of Dr. Kurtz:

Plaintiff's lawyer: "Tell me about your conversation with Dr. Schelble."

Hospital's lawyer: "Objection. I'm not going to let him answer."

Plaintiff's lawyer: "Why is that?"

Hospital's lawyer: "It's my understanding you can establish with him that it's his belief Dr. Schelble was doing a review based on a death that occurred within so many hours of a presentation which is, as I would understand it, peer review."

Plaintiff's lawyer: "Why is it that Dr. Schelble called you in?"

Dr. Kurtz: "He just wanted to go over what had happened."

Plaintiff's lawyer: "Was it just you and him alone?"

Dr. Kurtz: "Correct."

Plaintiff's lawyer: "And did he say anything beforehand about that he was conducting some kind of review for the hospital or conducting some kind of investiga-

tion or did he just say I want to talk to you about what happened?"

Hospital's lawyer: "Objection. You can ask him what his understanding was. I'm not going to let him start talking about what Dr. Schelble talked to him about."

Plaintiff's lawyer: "Let me put it to you this way, were you made aware in any way that this was some kind of standard hospital review?"

Hospital's lawyer: "Objection."

[Court reporter repeated the question.]

Hospital's lawyer: "I'll object, but you can answer that."

Dr. Kurtz: "My understanding is he just wanted to review what had happened."

Plaintiff's lawyer: "With you?"

Dr. Kurtz: "Quality assurance-type thing is my understanding."

After this discussion, the attorney for the plaintiff asked still more questions regarding the content of the conversation between Dr. Kurtz and Dr. Schelble, including:

- "Tell me exactly as you recollect the questions that Dr. Schelble asked you when he called you in to talk about this a couple of days after the incident"; and
- "Tell me anything else you can remember about that conversation with Dr. Schelble a couple of days after, I guess it would have been, March 9, 2005."

However, on advice of his counsel Dr. Kurtz refused to answer these questions.

The Peer Review Privilege

In a courtroom, the rules of evidence determine what testimony is admissible.[3] Generally, evidence is admissible if it is relevant.[4] An exception to the general rule exists where a privilege applies.[4] A privilege is a special situation where even though the testimony is relevant and would aid a court and jury in determining the outcome of the case before the court, public policy or a greater consideration dictates that the testimony should not be admissible. Examples of privilege include spousal privileges, doctor-patient privilege, attorney-client privilege, and medical peer review privilege.

The objective of the peer review privilege is to encourage scrutiny of medical care so that a hospital and physician can ensure that the standard of care is being followed. Physicians and other staff members must be free to candidly discuss situations that have occurred without the fear of litigation in order to achieve the peer review objectives.[5]

Peer review privilege is a statutorily protected privilege in Ohio, as it is in other states, and only applies to civil (and not criminal) matters.[2] Statutory privileges however, being in derogation of common law, are strictly construed by the courts.[6] Therefore, the peer review privilege is not absolute, and in order to protect the privilege certain criteria must be followed.[1,7] Additionally, the party claiming the privilege has the burden of proving that the privilege applies to the requested information.[1]

For example, the privilege does not extend to information "within the individual's knowledge."[1,2] Importantly, this means that while information a person learns within the peer review committee is privileged, personal knowledge learned outside the committee format is not privileged. Moreover, information can not be presented to the committee by the original sources simply to prevent its admissibility at future litigation.[1] Witnesses cannot be forced, though, to testify regarding what was said or discussed during the peer review process.[1]

In Ohio, it is a judge (not a jury) that is charged with determining whether certain testimony falls

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within the peer review statute.[1] The physician or hospital claiming that certain testimony is protected by the privilege has the burden of proving to the judge that the privilege does indeed apply to the given situation.[1]

At a bare minimum, the party claiming the peer review privilege must show that a peer review committee existed and that it actually investigated the incident. A discussion among peers of the type usually had in preparation for a peer review proceeding, such as between the two doctors in this case, is not alone sufficient to gain the protection of the peer review privilege.

The hospital or physician must also establish that the information sought falls into one of the categories of testimony protected by the statute. Under the Ohio statute, similar to most states, a physician *cannot* be asked at deposition to reveal:

- His or her testimony before the peer review committee;
- Information the physician provided to the committee; or
- Opinions the physician formed as a result of the committee's activities.

In summary, when presented with a claim that certain testimony is privileged, a court will consider the following before determining whether testimony is within the peer review privilege:

- Proof of existence of a peer review committee;
- Proof the peer review committee investigated the incident;
- Whether the privilege applies generally; and
- Whether requested testimony falls within testimony protected by statute (including testimony or information provided to committee, or opinions formed due to committee investigation).[1]

To ensure that investigations of an incident will fall within a state peer review privilege, it is important to make sure that each of these elements is satisfied.

Decision of the Appeals Court

The court held that the hospital failed to carry its burden of proof that the conversation between Drs. Schelble and Kurtz was protected by the Ohio peer review statute.[1,2] Therefore, the appellate court ordered Dr. Kurtz to answer questions regarding the content of his discussion with Dr. Schelble.

The court agreed that the hospital had a process for "performing quality assurance reviews of patient care" and that Dr. Schelble was part of that process. (Not long after the incident, Dr. Schelble died, so he obviously couldn't testify to the nature of his conversation with Dr. Kurtz. Instead, the hospital had the physician senior vice president of the medical staff provide an affidavit stating that Dr. Schelble, as chairman of the Department of Emergency Medicine, was responsible for performing quality assurance reviews and that as part of that process "would conduct interviews with the individual care providers involved in the patient's care that was the subject of the review.")[1]

However, the court determined that the hospital failed to meet its burden of proof that its peer review committee ever initiated or conducted any actual review of the patient's death. It viewed the conversation between the two physicians to be a private one, since it was not clearly delineated at the beginning of their discussions that review of the incident was to be part of a formal peer review investigation.

The court considered Dr. Kurtz's last comment in his deposition, when he said, "Quality assurance-type thing is my understanding." But the court noted he repeatedly answered plaintiff's attorney that Dr. Schelble just wanted to talk about what happened, and only after his own lawyer's repeated objections on the peer review privilege did he mention "quality assurance." Thus, the court concluded that Dr. Kurtz's statement speculating on Dr. Schelble's purpose for the meeting was not evidence and was insufficient to carry the hospital's burden of showing that his conversation with Dr. Schelble was conducted as part of a peer review process.

Therefore, because the hospital could not prove that the conversation was part of a peer review committee proceeding, it could not invoke the privilege.[1]

Conclusions

This case illustrates the importance of implementing and following clear formal processes when faced with a potential incident that could lead to litigation.

Peer Review Process: Lessons Learned

- Know how your state law defines the peer review process and the elements necessary to invoke the peer review privilege.
- Establish policies and procedures that are certain to incorporate expected conversations and materials into the peer review process, and which definitively protect the privilege.
- Follow your hospital's peer review procedures religiously, and carefully document compliance with them in all situations.
- Recognize that you will have to prove compliance with state peer review requirements to assert the privilege and protect discussions from discovery by plaintiff attorneys.

Had this conversation occurred after a formal peer review committee was formed, or had the two parties to the conversation been more transparent about the reasons for the discussion, the court would have been able to rule that the conversation fell under the peer review privilege. Undoubtedly, the hospital's defense was hampered by the inability of its ED chairman to testify due to his untimely death.

To protect peer review materials, it is very important for physicians and hospitals to understand the applicable state and federal rules. Strict compliance with these requirements is essential to protect the peer review process. It is also important to understand the limitations of the peer review privilege and to consult an attorney when necessary to protect testimony before or related to the peer review committee proceedings.

References

1. *Giusti v. Akron Gen. Med. Ctr.,* 2008-Ohio-4333 (9th Dist. Ct. App. 2008).
2. Ohio Revised Code (O.R.C) § 2305.252
3. See generally, Fed. R. Evid. 501. The Federal Rule of Privilege looks to the common law developed in each state to determine what testimony is privileged in a particular matter.
4. See generally, Fed. R. Evid. 104
5. Institute of Medicine (IOM). Kohn LT, Corrigan JM, Donaldson MS, eds. *To Err Is Human: Building a Safer Health System.* Washington, DC:National Academy Press;2000.
6. *Weis v. Weis*, 147 Ohio St. 416, 428 (1947).
7. E.g., *Adkins v. Christie, et al.,* 488 F.3d 1324 (11th Cir. 2007) (Ruling that the medical peer review privilege does not apply to federal discrimination claims).

Does proving an ED was crowded help or hurt in a lawsuit?

Finger-pointing can make defense more difficult

Some EDs have adopted the practice of documenting overcrowding, either by flagging patient charts or electronically recording the information with software, to pinpoint exactly how busy—and possibly, how understaffed—the department was on a given time and day. But is this going to help or hurt the ED physician in the event of a malpractice lawsuit?

The answer may depend on how unusual the situation is. "If there was an extreme surge in patients, such as after an explosion, and the hospital had a reasonable multicasualty incident plan and it was activated appropriately, then crowding would be a good defense," says **Robert Shesser, MD**, professor and chair of the department of emergency medicine at George Washington University. "If it was just an average busy day, then probably not."

As a general concept, it is typically not a good idea for the ED physician to blame a busy ED or overcrowding for a less-than-ideal outcome, according to **Matthew Rice, MD, JD, FACEP,** an ED physician with Northwest Emergency Physicians of TEAMHealth in Federal Way, WA.

Acknowledging an issue that makes the hospital or ED physician appear to have fallen below the standard of care will likely make it easier for the plaintiff's attorney to show that a breach of duty occurred, Rice explains.

Although it is often tempting to point a finger at a situation that made care difficult, this is probably not the best tactic to use in litigation proceedings. "Doing such often makes the defense of a case difficult for all involved," says Rice. "A jury is often not sympathetic to a patient's inability to receive the best of care."

Even if it might be helpful to an individual provider's case in pointing out real or perceived deficiencies within the system, such blame would only assist in the plaintiff's claims against the hospital or others, notes Rice.

"This may well weaken the defense by others, and

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most certainly would damage the relationship between the ED physician and the hospital," says Rice. A better approach, he says, would be to acknowledge that oftentimes ED systems are stressed, but there are procedures in place to prioritize care and find the best care for all patients in a timely manner.

Documentation of severe overcrowding "might simply be viewed as an attempt to shift liability from the ED physician to the hospital and or medical director for failure to have adequate plans and policies in place to handle surge," says **Edward Monico, MD, JD**, assistant professor in the section of emergency medicine at Yale University School of Medicine in New Haven, CT.

"Documentation of severe overcrowding might benefit ED physicians if an altered standard of care is accepted during times of severe overcrowding," says Monico. "To date, this has not been the case."

A jury's reaction to evidence showing that the ED was understaffed might depend "on the scenario and the skill of the attorneys involved," says Monico.

"At this time, I doubt damages would be mitigated by a showing of overcrowding. Liability shifting or simply serving to identify more defendants might be the more realistic result," says Monico. "Plaintiff attorneys typically aren't interested in where the fault lies, as long as it lies with someone."

What should you document?

At rare times, such as a mass casualty incident, it might be useful to document an unusual situation when the ED is overwhelmed, advises Rice. "In those circumstances, it would be important to document what actions were taken to enhance care and resources with the increased demand," he says. This way, if there is subsequent litigation, you'll have evidence of recognition of the crisis and an appropriate response to the event.

More important, though, is to preplan for the high-volume situations. "Have a plan in place to assure that patients with the greatest problems are provided the right care," says Rice.

If you work in a system that is unresponsive to critical needs for staffing, with a lack of focus on patient care and safety, this must be addressed, says Rice.

"In an unsafe environment, both the provider and the system will have difficulty defending poor outcomes when resources are below reasonable standards for whatever reason, no matter who or what is blamed," says Rice.

James Hubler, MD, JD, assistant clinical professor of emergency medicine at the University of Illinois College of Medicine at Peoria, says that in most of the cases he has seen involving alleged delay in treatment, and even ordinary negligence, the issue of how crowded the ED was on the day or night in question was raised.

"Obviously, jurors are more sympathetic toward a physician for having to multitask on numerous sick patients at one time," he says.

Hubler notes that all ED patients are logged in, to comply with Emergency Medical Treatment and Active Labor Act (EMTALA) requirements. "If years later, the capacity of the ED is in question, it can be verified by using the log book and pulling the records," he says.

If an ED physician is just starting a shift and encounters an emergent patient who was mistriaged as non-urgent, it may be of value to proactively document

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Suggested Reading

Ethical implications of ED crowding

Two upcoming *Annals of Emergency Medicine* articles serve as excellent discussions of the practical and ethical implications of emergency department crowding.

"Emergency Department Crowding, Part 1—Concept, Causes, and Moral Consequences"[1] and "Emergency Department Crowding, Part 2—Barriers to Reform and Strategies to Overcome Them,"[2] are part of a discussion of crowding and ethics in emergency medicine.

The authors state, "Crowding has a variety of undesirable consequences, including increased patient waiting times, decreased ability to protect patient privacy and confidentiality, impaired evaluation and treatment, and difficulties in delivering person-centered care. These consequences can be understood not just as undesirable or unfortunate but also as violations of widely held, fundamental moral norms."[1]

The authors define crowding terminology, discuss root causes, delineate moral consequences, and review barriers to overcome as well as potential strategies for overcoming these barriers.

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1. Moskop JC, Sklar DP, Geiderman JM, et al. Emergency Department Crowding, Part 1—Concept, Causes, and Moral Consequences. *Ann Emerg Med* 2008;Nov 20. (Epub ahead of print)
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SPECIAL REPORT

Seven Ways to Succeed in Getting Sued (without Really Trying)

*By **Bruce David Janiak**,MD, FACEP, FAAP, Professor of Emergency Medicine, Medical College of Georgia, Augusta.*

(Executive Editor's note: *Dr. Janiak has served as an emergency medicine medico-legal consultant for over 30 years, and has reviewed hundreds of malpractice cases. In the process, he has recognized common patterns and mistakes that emergency physicians make that set them up to be sued.*

This article takes a tongue-in-cheek approach to pointing out potential mistakes and ways that lawsuits might be avoided.)

• Don't communicate.

If you want to get sued, don't bother to explain your approach to the patient's problem or share decision making with the family. Patients would like to hear what you are thinking. This information and communication event gives them an opportunity to express their expectations. Remember that unmet expectations are a root cause of unhappiness in all of life (even if it's too long a wait at McDonalds).

For example, "I am concerned about your grandfather's fever. We are going to do some labs and a chest x-ray. If these results are all negative, then I believe he will be able to go home, since he looks otherwise okay." Now the plan is set, the relatives have a chance for buy-in, and your pathway should be relatively smooth.

Contrast this approach with the more absolute comment, "The labs are okay, so he has a virus and can go home." If grandfather deteriorates in the next few hours at home, you want a family that shared in the decision making.

Another version of the same theme is the failure to recognize their need for communication. Have you ever purposely avoided the eyes of that relative or patient leaning on the doorway into the room? They often want reassurance that they have not been forgotten. Even if Mr. Smith in room 6 is not your patient (this refers to both physicians and nurses), take a second to ask, "May I help you"? This gesture may go a long way toward mitigating the building anger or frustration fueled by an unexpectedly long wait. And there is a side benefit when you confirm that you actually did put in a call "30 minutes ago"; some of the building frustration can be shared with the party actually responsible (e.g. the slow consultant). Finally, offering the patient a blanket because he or she is in a frigid room says more than a thousand solicitous words and is an awesome way to communicate to your patients that you care.

• Don't do what the patient requests.

As emergency physicians, we frequently are told, "My doctor sent me in and said you should call her as soon as I arrive." Knowing that we have not yet done an evaluation, it is natural to assume that the primary care physician will want the benefit of our history, physical, and testing results. By following this natural assumption, you may find yourself in a "lose-lose" situation. Refusal to contact the requesting doctor gives the patient evidence of your lack of caring and concern. Furthermore, perhaps the primary care physician (PMD) did want early contact and will facilitate admission, consultation, or provide invaluable background information. If anything goes wrong, the patient will be upset and the PMD will stand by the patient.

This is especially true of the curmudgeonly consultant. (You know and dread him. Calls to him are unpleasant, and every time you speak with him he treats you like an intern.) This consultant will certainly claim, "I would have come in immediately if the emergency doc had only called. As it was, he waited for the CT result and it was too late to save your husband." Don't be afraid of conflict. After all, you must be the patient advocate.

• Be sure to over-test, since that will protect you from a successful suit.

This concept is all-pervasive, and we all practice some defensive medicine. The bottom line here is that overly defensive test-ordering makes your defense in a lawsuit more difficult. For example, a patient presents with fever and a negative history and physical examination. You are sure you are dealing with a virus, but order a complete blood count (CBC) just to be sure. The white blood cell count (WBC) is, unfortunately, 18,600 with a slight shift to the left. Because the patient looks great, he goes home only to return with something awful and infectious. You and your defense expert will be grilled on the CBC alone. In truth, these cases are much more defensible when labs are not done. You must ask yourself, "What will I do with abnormal results?" Your expert will have an easier time saying that the tests were not indicated than saying that grossly abnormal results were not a harbinger of the doom that is already evident at trial.

• Place little to no emphasis on the discharge process.

We who practice emergency medicine have done very well with the initial portions of the emergency department (ED) experience. Our triage and registration processes are streamlined, and the clinical evaluations of emergency specialists are light years ahead of what we did 20 years ago. Yet the end point, the discharge process, has changed little. I have seen the scribbled "F/U with PMD PRN" more times than I can count. (I often wonder what the average patient thinks "F/U" means.)

Discharge instructions need to be more specific. "See Dr. Hughes within 2 days, or sooner if worse" is more appropriate, especially if the patient deteriorates unexpectedly. The patient's failure to follow specific instructions will help should litigation ensue.

Conversely, open-ended instructions will weigh against the emergency physician in a similar circumstance. For example, a patient comes to the ED several times over several months with "pneumonia." All of his discharge instructions are vague regarding follow-up. His lung cancer remains undiagnosed and a lawsuit follows.

• Assume no one is listening (even the dead and dying).

After a prolonged resuscitation, I once pronounced a patient dead only to have her revive on her own shortly thereafter. Following her discharge from the hospital, she sought me out, declaring, "I heard everything you guys were saying." Although this is an extreme case and, thankfully, all staff members were professional, I was reminded of how vulnerable we can be to off-the-cuff comments.

Patients do not like listening to our vacation stories or comments about our favorite wines whey they are in distress. Keep personal comments and stories out of earshot. Bad results combined with comments about our behaviors are supportive of a jury's judgment about our credibility.

• Don't be afraid to mention the word "appendicitis."

We have all heard the relative exclaim, "I know someone who had this same pain and later died of appendicitis." Take the time to address these concerns with an acknowledgment of the patient's impressions and concerns. Indicate that you, too, have thought about this diagnosis and why a particular diagnosis isn't or is included in your differential.

When appropriate, bring up other possible and reasonable scenarios and outcomes that might be associated with a patient's chief complaint and presentation. Counsel them that appendicitis is a potentially difficult diagnosis, and that time may have to pass for you to make a definitive diagnosis. Discuss with them the pros and cons of the computed tomography (CT) scan, including a significant radiation exposure. You may be surprised that some people will opt to return the next day for a repeat examination rather than have the CT scan.

These discussions can also serve to educate the patient's family that a return visit for a repeat evaluation is an acceptable diagnostic approach. In addition, simple reassurance may be another valuable outcome: "Thank you for asking the question. Yes, appendicitis is a possibility, but usually we find the pain associated with appendicitis in the right lower

'Little things' foster connection with patients

What are the things that physicians who have successful and therapeutic relationships with their patients do more or less consistently? Churchill et al.[1] interviewed 50 medical professionals judged by their peers to be especially good at sustaining excellent patient relationships. In their article published in the *Annals of Internal Medicine* in 2008, they summarize the themes that seem to correlate with a healing relationship with patients:

- *Do the little things.* Introduce yourself, greet everyone in the room, shake hands, smile, sit down, make eye contact, give undivided attention.
- *Take time to listen.* Be still, quiet, interested. and present.
- *Be open.* Be vulnerable and don't avoid the pain; look for the unspoken.
- *Find something to like, to love.* Think of your family, take the risk, stretch yourself.
- *Remove barriers.* Acknowledge power differentials, practice humility, create bridges, make welcoming spaces.
- *Let the patient explain.* Listen for fear and anger, listen for expectations and hopes.
- *Share authority.* Offer guidance, ask permission, enable the patient's autonomy.
- *Be committed and trustworthy.* Do not abandon; invest in trust, be faithful.

1. Churchill LR, Schenck D. Healing skills for medical practice. *Ann Intern Med* 2008; 149:720.

quadrant and not on the left side."

Nevertheless, in the event of a bad outcome, avoiding tough questions like the proverbial ostrich and refusing to acknowledge their fears or even the possibility that their family member might have a more serious condition can set one up for a lawsuit.

• Ignore complaining patients, and don't call them back.

Having called back many complainers over the years, I have learned much about how we are perceived. While often painful experiences, they are truly opportunities for improvement. The primary issue in almost every situation includes a communication failure. We tend to see a patient, order a test or two, and then return to discuss results. This is acceptable when the department is busy, but when you have the time, just sit (yes, sit) and chat for a few minutes. You may find that the true reason for the visit will be disclosed. It's possible that even though you are practicing good emergency medicine, you are not meeting the patient's expectations.

ED directors can miss an important opportunity to learn about operational problems or staff behaviors that need correcting. In reality, the astute management of a patient's complaint can sometimes turn an unhappy customer into an ardent fan of your service and a return customer.

Finally, patients may complain simply because they feel "no one cared," and by the physician not responding, that feeling is reinforced. Opportunities to defuse a potentially litigious situation or public relations boondoggle may be missed.

We all need to do more communicating and less testing. *(See "Little things," page 31.)* Don't be afraid to ask specifically, "What is your primary concern?" or "What did you expect me to do for you today?" In reality, the best way to get sued is to actively or passively treat patients contrary to how you would like to be treated if you were in their shoes. All the testing you can do will not overcome the combination of a bad outcome and a perceived bad attitude.

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that there were long waits in the waiting room, adds Hubler.

"If the shift has just started, I would document this information as well. It will help protect the physician, but not the hospital," says Hubler.

However, documenting that the ED was overcrowded may be of detriment if there has been no attempt to remedy the situation. Hubler notes that the plaintiff's attorney may ask: "Why didn't the physician call in additional physicians? Why didn't the ED go on bypass? Why weren't additional nurses called in?"

Crowding could be a defensible argument

According to **Jesse M. Pines, MD, MBA, MSCE,** assistant professor of emergency medicine and epidemiology at the Hospital of the University of Pennsylvania in Philadelphia, whether crowding should be documented "can be difficult to sort out in hindsight, but I think it is very important legally to the emergency physician." Crowding, he notes, is clearly associated with poorer outcomes and quality of care.[1,2]

And since the major cause of crowding is caused by the practice of boarding admitted patients in the ED, and this is out of the control of the individual emergency physician, attributing a particular error or poor outcome at least in part to the crowded state of the ED "may actually be a defensible argument," says Pines. "Personally, I have not seen cases where this has been used. But the literature on the topic is relatively recent. We may see cases in the future where a 'too crowded' defense is used."

However, Pines notes that hospital lawyers represent the entire hospital. So while this documentation may protect one party—the emergency physician—it could leave the hospital in a worse legal position. "This is particularly true in the era where the conventional wisdom is that hospitals are in part to blame for their own crowded conditions in the ED," he says. "What it may do is direct anger away from the emergency physician and at the hospital."

Pines adds that there are several peer-reviewed papers that have associated crowding with poorer quality care, including pneumonia, pain control, and cardiac care.

"Certainly, in these cases, if there is a bad outcome, lawyers may point to the literature to help justify what may have happened," says Pines.

Pines says that his conclusion is that documenting severe ED crowding "can't hurt, especially if there is a critically ill patient or a poor outcome that occurs."

"But the truth is that when patients are recognized as critically ill, resources are typically directed towards them regardless of how crowded it is," says Pines. "The problem comes for other patients who are there in the same ED with a critically ill patient."

If resources are insufficient to care for both patients—if, for example, a trauma patient pulls resources from a patient with acute coronary syn-

drome—there is evidence to show that outcomes can be worse in the acute coronary syndrome patient.

"So, it is not only important to document the crowded state, but also that resources were directed to another, more critically ill patient," says Pines.

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Does your ED patient have a case against you?

Weak cases will get "weeded out"

Being served with papers indicating a patient has sued you is a shocking and upsetting moment. However, this doesn't necessarily mean the case is valid—or even that it will go forward at all.

For a patient to prevail in a medical malpractice case against an ED physician, he or she must prove three things: The appropriate standard of care, the doctor's deviation from the standard of care, and a proximate causal connection between the doctor's act or omission causing the breach and the injury sustained by the patient.

"The patient must prove each of these elements by a preponderance of the evidence, which means that the existence of each must be more probable than not," says **Joseph J. Feltes**, a partner with Canton, OH-based Buckingham, Doolittle & Burroughs. "This is a lesser standard than in criminal cases, which require proof beyond a reasonable doubt."

Standard of care may not be what you think

"Sometimes people misunderstand how the standard of care is defined in a specialty like emergency medicine," says **Steven Davidson**, a partner with Omaha, NE-based Baird Holm. "The standard of care is set by the specialty itself, rather than something higher than that."

This means that an ED physician is obligated to respond like other ED physicians would respond, not as a specialist with the highest possible level of knowledge about a condition would respond.

Often, plaintiffs attempt to hold physicians to an unobtainable standard of care. "An ED physician is not required to be a miracle worker. Certain patients are beyond what medical science can do for them," says Feltes.

He notes that a Louisiana court recently exonerated an ED physician from malpractice for doing "an excellent job in a horrendous situation" when a patient presented with profuse bleeding.[1]

The standard of care for an ED physician, says **Barbara Pilo**, a counsel attorney in the litigation section of the Dallas office of Fulbright & Jaworski LLP, should take into account the many variables which may be involved in emergency care. These may include the presentation of an acute condition, the need for prompt action, the lack of a pre-existing physician relationship, and the unavailability of a comprehensive medical history.

"An emergency department physician should not be judged according to the standards of another medical specialty field," says Pilo. "The standard of care relevant to a physician, or other health care provider in the emergency department, will be the conduct of a reasonably prudent physician, nurse, or technician, in an emergency room context."

In some cases, the ED physician's conduct may fall below the standard of care, but in fact, is unrelated to the outcome that the patient is claiming damages for. "That is always something that defense counsel will look at, especially in cases where there was a clear breach of the standard of care," says Davidson.

For example, the patient's bad outcome may have happened regardless of what the physician did, or could have been the result of something a different provider did.

"There are countless ways in which other events may have intervened to cause a result that breaks the chain of causation with the act that the ED physician is getting sued for," says Davidson.

Damage must be connected to breach

It's not enough for the plaintiff to show that the standard of care was breached-he or she must have suffered damage as a result of that breach. "It is easy to hypoth-

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esize how substandard care might be shown to exist in the absence of any injury," says Pilo.

For example, an ED patient may be able to prove that a miscommunication between ED staff caused an excessive delay for treatment. "As a legal matter, such a complaint will be destined to fail if the plaintiff did not suffer harm," says Pilo.

Unless the patient can prove that an injury was caused by the delay in treatment, as opposed to the condition which brought the individual to the ED in the first place, "proof of an essential component of a malpractice case will be lacking," says Pilo.

In situations where a patient has less than a 50% chance of survival when presenting to the ED, most states have created a cause of action for "loss of chance," wherein the patient must prove that the physician's negligence increased the risk of harm to the patient.

"This operates as an exception to proof of proximate causation," says Feltes. "Under these circumstances, damages can be awarded based on the percentage of chance the patient lost."

For example, an Ohio court recently found that a plaintiff could recover under "loss of chance" principles. "In that case, the plaintiff's expert testified that the patient had a 10% to 40% chance of survival if operated on between the time of arrival and the time she was pronounced dead," says Feltes. "The failure to properly triage the patient caused him to lose this 30% chance of recovery."[2]

Judgments that the ED physician makes between multiple alternatives, both of which are acceptable alternatives, typically are generally are not enough to generate liability.

"Sometimes you will see a physician get sued for choosing to handle a patient in a particular way, when really what is happening is they are exercising professional judgment," says Davidson. "Doctors can choose between two acceptable courses of care. A bad outcome for that choice is not something you can fairly be sued for."

When evaluating the proof of what constitutes compliance with the standard of care, it must be noted that there may not be a single valid response in a given medical emergency, says Pilo.

In other words, simply contending that another physician may have acted differently under the circumstances, or preferred another mode of treatment, isn't enough to establish a departure from the standard of care.

"The standard of care may consist of a range of acceptable medical conduct," Pilo says. "Second guessing a close judgment call generally doesn't make for a successful medical malpractice case, particularly if a defendant can make a convincing showing that an acceptable mode of treatment was followed."

Even if the patient can demonstrate an injury attributable to emergency care, without proof of a departure from the applicable standard of care, a case of medical negligence against an ED physician will be insufficient. "Even in the presence of injury which may be the consequence of treatment in the emergency department, an unsuccessful outcome does not necessarily imply substandard care," Pilo says.

According to Pilo, "Despite the existence of an unfavorable result for the patient, if proof can be shown that the applicable standard of emergency care received compliance under the circumstances, a defendant in a medical malpractice case should prevail."

Checks and balances come into play

Poor outcomes, standing alone, are not enough to create a claim. "These happen every day in the ED, typically notwithstanding a physician's best efforts," says Davidson. "Anybody who can find a lawyer to take their case can sue, but the claim won't be successful just by virtue of a poor outcome."

This is because the patient needs to prove that the standard of care was breached, which typically requires the testimony of an expert. "You need another doctor to say, 'I'm familiar with ER care and know what physicians are supposed to do, and I have reviewed this file and this physician failed to meet that standard in these particular ways,'" says Davidson. "That is a lot different thing to prove than 'I went to the ED and had a complication,' or 'I wasn't treated timely and had a bad outcome.'"

Judges are, in fact, required by law to make sure in their own mind that the evidence is sufficient to support a verdict. "And if it's clearly not, there are procedures we can use to ask the judge to reverse the verdict for insufficient proof of the elements of the claim," says Davidson. "In cases where there isn't more than a bad outcome, usually the judge will dismiss those before they go to trial."

Sometimes, for example, cases get dismissed early in the process when the plaintiff fails to identify an expert witness who can support their claim.

"There are lawyers who will take weak cases and will find experts to say things for them. And those cases can be dangerous, obviously," says Davidson. "But usually the flaws in those tend to come to the surface by the time you work your way through your case."

The problem is that it takes a while for this to occur, which means the ED physician has to spend time and money until the case is in front of a judge and can be dismissed.

"I suppose that's the dark side of the jury system," says Davidson. "But more times than not, judges usually see through that. They will weed out claims that

really shouldn't have been filed or should not go to a jury."

If a case is weak, this is usually revealed before you are sitting in the courtroom with a judge and jury. "There are several points in the course of a lawsuit where the system builds in checks and balances on the claim," says Davidson. "The plaintiff will have to produce evidence and establish the validity of the claim."

For this reason, a big part of the defense lawyer's job, says Davidson, is "if the case is one that you can get rid of at an early stage, we work hard to get that done. You see a fair number of cases where you go through those initial stages, then the plaintiff's lawyer realizes, 'I'm not going to be able to prove this' and walks away. That's not infrequent."

Proper documentation—of medications administered, tests ordered, and patient monitoring—is oftentimes "the key to avoiding otherwise baseless malpractice claims," says Feltes.

Communication between ED physicians and nurses, as well as between residents and attending physicians, also becomes an important issue. "If an action is taken and not charted, plaintiff attorneys will often argue that it did not happen," says Feltes. "This places the credibility of the physicians and nurses at issue."

If the standard of care was legally met, but the jury is presented with testimony that indicates otherwise, this is a troubling situation. "If you find yourself justifying your conduct through fine distinctions, and you've got a sympathetic plaintiff with a serious problem, those cases can get difficult," says Davidson. "That's when I start talking to the client and insurance company about whether and how to settle, so they can avoid a huge adverse outcome."

In these cases, the jury's perception of the ED physician who is being sued becomes very important. For the most part, Davidson says that juries start with the presumption that doctors know what they are doing and their judgment can be trusted. However, if the doctor comes off as arrogant when testifying about his or her actions, this can quickly change the jury's good opinion about the physician.

For this reason, being able to explain to laypeople the decisions you made and the care you gave becomes critical. "If you combine a physician who is a poor communicator who doesn't bond with the jury very well, with a set of facts that is arguable about the judgment that is being made—those are the cases that scare me," says Davidson.

References

1. *Willis v. Smith* (La.App. 2 Cir. 1/14/09), 2009 WL 81146.
2. Natoli v. Massillon Community Hospital (Ohio App. 12/1/08), 2008 WL 5077636.

CNE/CME Objectives

After completing this activity, participants will be able to:

1. Identify legal issues relating to emergency medicine practice;
2. Explain how these issues affect nurses, physicians, legal counsel, management, and patients.
3. Integrate practical solutions to reduce risk into the ED practitioner's daily practices. ■

CNE/CME instructions

Physicians and nurses participate in this CE/CME program by reading the issue, using the references for research, and studying the questions. Participants should select what they believe to be the correct answers, then refer to the answer key to test their knowledge. To clarify confusion on any questions answered incorrectly, consult the source material. After completing the semester's activity, you must complete the evaluation form provided and return it in the reply envelope to receive a letter of credit. When your evaluation is received, a letter of credit will be mailed to you. ■

CNE/CME *Questions*

9. Per *Giusti v. Akron Gen. Med. Ctr.,* a court will consider which of the following in determining whether testimony is protected by peer review privilege?
   A. Proof of existence of a peer review committee
   B. Proof the peer review committee investigated the incident
   C. Whether requested testimony falls within testimony protected by statute (including testimony or information provided to committee, or opinions formed due to committee investigation)
   D. All of the above

10. Which is *true* regarding documentation of ED crowding and liability risks?
   A. Crowding could be a good defense if an extreme surge in patients after a mass casualty incident occurs, and the hospital activated a plan appropriately.
   B. Blaming overcrowding is recommended as a defense for a poor patient outcome because it makes it more difficult for the plaintiff's attorney to show that a breach of duty occurred.
   C. Ideally, documentation should show that inadequate procedures were in place to prioritize care.
   D. During times of severe overcrowding, ED physicians should avoid documenting what actions were taken to enhance care and resources with the increased demand.

11. Which statement is *true* regarding the standard of care that a plaintiff must prove to support a claim of ED malpractice?
   A. The ED physician is obligated to respond as another ED physician would respond in a similar situation.
   B. The standard of care would not under any circumstances include a range of acceptable medical conduct.
   C. The standard of care for an ED physician should not take into account variables such as the need for prompt action.
   D. In most cases, it's acceptable for an ED physician to be judged according to the standards of another medical specialty field.

12. Which of the scenarios below could potentially constitute a successful ED medical malpractice case?
   A. If the ED physician's conduct falls below the standard of care, but in fact, is unrelated to the outcome that the patient is claiming damages for
   B. If the standard of care is breached, but the patient's bad outcome would have occurred regardless of what the ED physician did
   C. If miscommunication between ED providers resulted in an excessive delay for treatment, which constituted a breach of the standard of care, but the patient was not harmed as a result
   D. None of the above

Answers: 9. D; 10. A; 11. A; 12. D