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Emergency Department Triage—The New Hotbed of Litigation?

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Historically, emergency department (ED) triage was rarely a high-risk issue for hospitals, primarily because short waiting times resulted in all patients being seen quickly by the emergency physicians. Today, the combination of overcrowding, markedly prolonged waiting times, increasing numbers of patients leaving the ED before examination, the nursing shortage, diminishing financial support, and federal Emergency Medical Treatment and Active Labor Act (EMTALA) mandates make triage a very dangerous encounter for the patient and a fertile source of litigation against providers.

Patient deaths in the ED waiting room, before evaluation by the physician, are increasing and now populate the news with frightening frequency. For example, late last year, a 58-year-old man died in a Texas ED waiting area after waiting 19 hours to see a doctor for abdominal pains.[1] Also last year, a 49-year-old woman collapsed and died on the waiting room floor of a New York City psychiatric hospital and lay there ignored for more than an hour. She had been waiting nearly 24 hours for treatment before expiring.[2]

Typical malpractice claims related to triage include:[3,4,5]

- Failure to rapidly or accurately assess the severity of the patient's medical condition resulting in delay in treatment;
- Delay in recognition of life-threatening illness or injury;
- Failure to monitor or periodically reassess patients waiting for care;
- Triaging the patient away from the ED without a medical screening exam (MSE) in violation of EMTALA;
- Delaying the patient's access to the federally required medical screening exam on account of their insurance status; and
- Failure to obtain an "informed refusal" or explain the risks of refusing care for patients who leave the ED against medical advice or before being seen by the emergency physician (AMA or LWBS).

To counter these claims, the hospital and ED medical director must devote substantial time, effort, and resources to establish an effective triage system. Too many hospitals leave triage to the domain of nursing leadership without critical involvement and

supervision of the emergency physicians. Also, too often the department's least experienced nurses are sent out to triage, or the ED "borrows" nurses from an inpatient unit or staffing service to work in triage, when in fact the complexities of the issues related to triage and the ramifications to patient safety from the prolonged waiting time to be seen by a physician demand exactly the opposite—the best and the brightest nurses need to be in triage.

Alternatively, and now more frequently, triage itself may be done by clinicians with greater training, such as PA, NPs, or the emergency physicians themselves.[6]

Every hospital triage system must address all of the following dozen issues:

➞ ***Identify who is qualified to conduct triage.*** Only nurses with substantial ED experience, recognized clinical skill, and excellent interpersonal and communication skills should be allowed to conduct triage for the ED.

One or two years of ED experience are probably inadequate; three to five years may be more reasonable. Whatever the number, the hospital and emergency physicians group need to agree on an acceptable minimum level of ED experience before a nurse is allowed to triage.

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The most necessary skill to triage is the ability to identify those patients who need immediate medical intervention to avoid morbidity or mortality—referred to in the vernacular as the aptitude to tell who's really sick and who isn't. This includes an understanding of the significance of abnormal vital signs and the ability to recognize the multifarious presentations of true life-threatening emergencies, including the not-so-obvious ones.

Nearly equal in importance are the requisite interpersonal and communications skills to deal with patients, families, EMS personnel, and physicians in a fast-paced, hectic environment that is often stressed to the max, and when the patients frequently aren't happy with the wait, the uncertainty, or the complexity of the health care maze. "People skills" is an art, and not everyone has the knack for it.

The triage arena is the hospital's window to the community and an integral piece of a competently run ED—so put your absolute best nurses out in triage.

➞ ***Utilize the designated qualified triage individuals at all times, not just during the busiest hours of the day.***

➞ ***Specifically train those individuals who will work in the triage area of the ED.***

Once individual nurses are deemed qualified to work in triage, they should be specially trained on the issues related to triage before actually performing triage functions. Draft a list of the issues the triage folks at your facility need to master and require them to demonstrate competence in those issues before they can begin working in triage.

➞ ***Advanced training on EMTALA issues.*** Triage is the primary touch point for persons coming to the ED, and EMTALA governs how the triage staff must interact with those individuals seeking medical attention.[7] Consequently, the triage nurses must be well versed on all matters EMTALA.

➞ ***Training in how to deal with patients who leave LBE or AMA.*** Triage nurses are often the target of angry or frustrated patients and they must be trained how deal with patients considering or intent on leaving the ED without receiving or completing examination or treatment. The comments or actions of the triage nurses must not be deemed as encouraging patients to leave nor unduly discouraging them from staying.

For example, in the case of *South Fulton Medical Center v. Poe,* an irate father demanded immediate examination of his infant child, who had become cyanotic at home, by the emergency physician. But the triage nurse refused, assuring the father that "the baby was fine now" and could wait to be seen. Not long after, the father and child left the ED and the child died hours later. A jury awarded the father $1.85 million primarily on the grounds that the triage nurse's assurances motivated the family to leave without examination or treatment.[8]

The LBE and AMA issues are significant potential liabilities for the ED under both EMTALA and ordinary state malpractice claims; these interactions must be handled carefully.[7]

➞ ***Ignore insurance status or financial issues.*** Insurance information should be removed from triage forms or process; triage decisions should be made without knowledge of the patient's insurance status. Triage all patients, then examine and treat them in the order as indicated by their medical acuity. Never delay the triage assessment or the medical screening examination (MSE) to obtain the patient's insurance information or collect payment of any kind.

In addition to the triage team, the entire clinical staff, including the nurses and emergency physicians, should be blinded to the patient's insurance status throughout the initial screening and stabilizing treatment. This removes insurance status as an issue should the government or a plaintiff's attorney later claim that the staff was motivated in some way or treated the patient disparately on the basis of financial class. It is easier to prove that actions were not predicated on the patient's financial status when one lacks knowledge of that status than to prove that one's actions were medically appropriate despite knowing the patient had no insurance.

Only after the MSE and initiation of stabilizing treatment can economic considerations be considered in determining the patient's future care, such as prescriptions, the admission or transfer decision, or discharge and follow-up arrangements.[9]

The triage staff should know how to handle patients who ask insurance or financial questions regarding their ED visit, such as whether their insurance will cover the visit or how much it will cost to receive care in the ED. The triage nurses (and registration personnel) should be trained to give "stock answers" to these questions and not discourage or coerce the patient in any way. Instead, they should encourage the patient to stay and defer economic discussions until after triage and a MSE is performed.

➞ ***Avoid errors with private or "VIP" patients.*** Members of the hospital's medical staff may choose to meet their private patients in the ED. These patients are examined and treated by their own physicians, not the emergency physician on duty. This practice is entirely appropriate to maintain physician–patient relationships and allowable under law.

However, the hospital should have prearranged procedures for handling private patients that do not delay the patient's MSE, or the hospital could be liable under EMTALA for failure to provide an "appropriate" MSE. Delay of treatment in such instances also frequently results in hospital liability through state malpractice actions.

All private patients should be triaged according to the hospital's established protocols. If the triage nurse determines that the patient requires immediate care, the emergency physician on duty should provide the necessary treatment until the patient's private physician arrives in the ED to assume the patient's care.

If triage determines that the patient does not require immediate care, the emergency physician should see the patient in the order consistent with the usual practice of the ED, generally in the order of acuity or time of arrival. If the private physician comes to the ED and sees the patient before the emergency physician, the examination by the private physician constitutes the required MSE by the hospital. Furthermore, there has been no undue delay of the MSE for any non-medical reason. However, if the patient's private physician has not arrived by the time the emergency physician would normally examine the patient, the emergency physician should perform a MSE. If no emergency medical condition (EMC) is evident, the patient can wait for his or her physician to arrive. If an EMC exists, the emergency physician should undertake appropriate stabilizing treatment until the patient's physician arrives.

In essence, regardless of private-patient status, "VIP" status, managed care status, or any other special classification, all patients should be triaged and processed in the same manner.

Hospital and medical staff policy must specifically address the issue of handling private patients presenting to the ED.[8]

➞ ***Interactions with EMS.*** Whenever EMS brings a person to the ED, the triage nurse's interaction with the EMS providers is controlled by EMTALA.

First, the nurse may not divert the ambulance off hospital property, regardless of whether the hospital is incapable of handling the patient's complaint (i.e., "We don't do trauma here"). The patient must be triaged and the emergency physician (or other "qualified medical personnel" formally designated to perform MSEs for the hospital) must perform an MSE before any patient can be transferred away from the hospital. Triage itself does not count as the MSE under federal law.

Second, even when the ED is overwhelmed, all EMS patients must be triaged upon presentation to the ED. Some overcrowded hospitals ignore ambulance patients and leave EMS to care for them until the hospital "accepts" the patient, a practice termed "EMS parking." These hospitals erroneously believe that unless they accept responsibility for the patient they have no EMTALA duty to provide care or accommodate the patient. CMS issued a memorandum reminding hospitals that their EMTALA obligation begins the moment the patient "comes to the ED" and a request is made on behalf of the patient for examination or treatment of a medical condition, not when the hospital "accepts" the patient.[10,11]

In a second memo, CMS later acknowledged that cir-

cumstances may exist, such as an influx of multiple trauma victims, where it would be reasonable for the hospital to ask the EMS provider to stay with the individual until such time as the ED staff became available to care for that individual.[12] However, it still mandated that:

"[E]ven if a hospital cannot immediately provide an MSE, *it must still triage the individual's condition immediately upon arrival* to ensure that an emergent intervention is not required and that the EMS provider staff can appropriately monitor the individual's condition." (*Emphasis added.*)[12]

Physician and nursing ED leadership should review the two CMS memos regarding interactions with EMS and educate the triage staff accordingly.[10,12]

➞ ***Policies and Procedures.*** The hospital must have clear and comprehensive triage policies and the triage nurses must be intimately familiar with them. These policies should include systems to handle volume surges and/or overload situations. The policies should address all the potential issues that the triage staff are likely to encounter (such as those on this list), particularly the EMTALA rules and regulations.

"Failure to follow your own rules" is a very common source of triage related litigation. Plaintiffs routinely try to prove they were harmed by the hospital by producing evidence that the hospital deviated from its own established triage or medical screening policies ('disparate treatment' claims under EMTALA or state laws.)[13]

In the case of *Clark v. Baton Rouge General Medical Center,* a woman presented to the ED with a severe stroke. After triage, her personal physician ordered her transferred to a higher level of care, but without an examination by the emergency physician on duty despite a family member's request for help after the woman vomited while waiting two hours for the transfer. The court held that the hospital deviated from its own policies, which required a medical evaluation to be provided to any person who requested one. It also held that the hospital violated EMTALA by failing to provide an "appropriate" medical screening exam as required by the law.[14]

➞ ***Monitor and periodically reassess patients waiting to be seen***. The triage nurses must monitor the condition of waiting patients at regular intervals, regardless of the patient's complaint. Policies should govern this aspect of triage, but be flexible and not be written in a way that hamstrings the staff into actions or timeframes they can't possibly meet at all times, particularly during the busiest shifts. The triage nurses essentially control flow in the ED and access to examination and treatment. They must remain vigilant in observing changes in the patients' condition that warrant changes in prioritization.

➞ ***Communicate, communicate, communicate.*** Triage nurses must be expert communicators and the hospital must train them on what to say and what not to say to patients presenting to the ED. For example,

- What do they tell patients who ask how long the wait is?
- How do they handle a "VIP" who insists on being seen immediately?
- How do they deal with irate families?
- When can the family go back to the treatment area with the patient? How many family members?

Nurses should not make judgments or assure patients that their conditions are not serious. Patients may decide to leave because of the long wait after being assured by the nurse (the hospital) that their condition wasn't serious. No matter how trivial the chief complaint may appear to be, there is no way to be certain that the patient doesn't have an emergency condition until *after* the MSE has been completed by the physician.

➞ ***Document!*** The elements of the triage record should be determined by the hospital with emergency physician input. The triage nurses should complete *all* the required essential elements on *all* patients presenting to the ED. Specific attention should be paid to the triage categorization that dictates the order in which patients are seen by the emergency physicians.

Compliance with the required documentation should be periodically monitored, and the judgment of the triage nurses regarding the acuity categorizations reviewed regularly. Nothing is more important to decreasing liability related to the triage functions.

In summary, the nurses with the most clinical experience, the finest clinical skills, and the best interpersonal/communication skills are the only nurses who should be allowed to triage for the ED. Furthermore, triage staff must be specially trained in all facets of triage, including the significance of abnormal vital signs and the recognition of true life-threatening presentations, patient monitoring, interpersonal and communications techniques with patients, families, and physicians, documentation issues, detailed knowledge of hospital policies, and particularly the EMTALA rules and regulations.

In today's overcrowded ED, triage is the linchpin to a functional patient care system and avoiding liability related to delay of care.

References

1. Cox L. ER Death Points to Growing Wait-Time Problem. ABC News Medical Unit, September 25, 2008. http://abcnews.go.com/Health/story?id=5884487.
2. CNN News July 1, 2008: Tape shows woman dying on ER waiting room floor. www.cnn.com/2008/US/07/01/waiting.room.death/index.html.]
3. Wuerz R, et al. Inconsistency of emergency department triage. *Ann Emerg Med* 1998;32:431-435.
4. *Carroll v Wake County Hospital Systems, Inc*. Medical Malpractice Verdicts, Settlements & Experts 1994;10(17) June. (Negligent triage/delay in examination by the emergency physicians of a patient with chest pain resulting in death in the ED;

case settled for $584,000.)
5. Thompson DA, et al. Effects of actual waiting time, perceived waiting time, information delivery, and expressive quality of patient satisfaction in the emergency department, *Ann Emerg Med* 1996;28:657-665.
6. Brillman JC, et al. Does a Physician visual assessment change triage? *Am J Emerg Med* 1997;15:29-33.
7. Bitterman RA. Providing Emergency Care under Federal Law: EMTALA, 2001; and Supplement 2004. American College of Emergency Physicians.
8. *South Fulton Medical Center v. Poe*, 480 S.E.2d 40 (Ga. Ct. App. 1996
9. 68 Fed. Reg. 53,221-53264 (2003); 42 CFR 489.24 et seq.
10. Centers for Medicaid and State Operations/Survey and Certification Group, Ref: S&C-06-21, July 13, 2006: EMTALA–"Parking" of Emergency Medical Service Patients in Hospitals.
11. The practice or "parking" of EMS patients may also violate Medicare regulations which require hospitals to "meet the emergency needs of patients in accordance with acceptable standards of practice." See 42 CFR 482.55.
12. Centers for Medicaid and State Operations/Survey and Certification Group, S&C-07-20, April 27, 2007: EMTALA Issues Related to Emergency Transport.
13. Bitterman RA. Overcrowded emergency department leads to lawsuit over EMTALA. *ED Legal Letter* 2008;19:133-136.
14. *Clark v. Baton Rouge General Medical Center*, 657 So.2d 741 (La.Ct.App. 1995)

How can expert witnesses make or break a lawsuit?

Involve experts early in the process

The credibility of "dueling experts" testifying before a jury often determines the outcome of a lawsuit alleging malpractice by an emergency physician, but in fact, expert witnesses typically get involved weeks before a case is even filed.

"Some savvy providers will hire an expert to review a chart as soon as a request for the medical record comes from a plaintiff attorney," says **Christy Tosh Crider,** a shareholder at Nashville, TN-based Baker, Donelson, Bearman, Caldwell & Berkowitz. "That way, if clear liability exists, quick steps can be taken to resolve the matter before it turns into nasty litigation."

It is always a good idea to know more than the opposition does, says Crider, and if you can clearly show no liability, early retention of experts can help convince the opposing attorney that there is no case worth pursuing.

A plaintiff usually hires an expert to review the ED chart to determine if they should file a lawsuit—in other words, to see if the chart indicates negligence on behalf of the hospital or healthcare providers, says **Linda M. Stimmel**, a partner with the Dallas, TX-based law firm of Stewart Stimmel.

On the defense side, the attorney representing the ED may hire an expert to review a chart even in the "claim" stage, when an actual lawsuit has not yet been filed with the court.

In a growing number of states, in fact, plaintiffs are under strict procedural guidelines to engage experts early on in the case—as early as the first 120 days—to show the court that the case is not frivolous.

"These pressures have led many plaintiffs' lawyers to do their homework long before even filing the lawsuit," says **Chris DeMeo**, a member at McGlinchey Stafford, PLLC, in Houston, TX. "More often than not, in big cases, the plaintiff's attorney will have worked on the case with experts months in advance."

While the defense does not typically have the same procedural pressures, and in many cases, may not even know of the claim until suit is filed, DeMeo says that it is still important to involve experts early.

For purposes of the lawsuit, the court may enter an order setting deadlines for the defendant to disclose expert witnesses. In the absence of an order, the rules of procedure will dictate when to identify expert witnesses, or in some cases, the parties can agree on a designation schedule.

"These deadlines, however, should be not be used for overall case management. Expert involvement should begin much sooner," says DeMeo. "Experts should be involved as early as the medical facts are known and understood, so as to begin development of the defense theory."

It is possible for the ED's attorney to provide an opinion by their own expert to try to convince the plaintiff to drop the claim. This is fairly unusual, however, says Stimmel, "because most of the time, the plaintiff already believes they have a case. The danger may be to 'show your hand' early."

"The advantage of being a defendant is that the plaintiff has to go first and show you their theories of negligence," says Stimmel. "This helps a defendant find the right expert and provide a stronger defense."

As for the ED physician using their own experts to get a plaintiff to drop a weak case early on in the process, DeMeo says "this can and does happen."

The most typical cases are those with a clearcut medical defense to causation based on the timing of the presentation to the ED. "In those instances, a credible, published expert who can explain why the condition was fatal or would have otherwise caused the injury at the time the patient arrived in the ED regardless of the care provided, can have claim dispositive effects," says DeMeo.

DeMeo notes that this is particularly true in states that do not recognize a "Loss of Chance" cause of action,

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SPECIAL REPORT

Legal Special Defenses: An ED Physician's Friend, and Sometimes Savior

*By **Gregory P. Moore, MD, JD,** Attending Physician, Emergency Medicine Residency, Madigan Army Medical Center, Tacoma, WA.*

We should all be aware of the four components of malpractice — the physician had a duty, breached the duty, there was harm to the patient, and the harm was caused by the breach of duty. Typically, if a lawyer proves all four elements are present, then the physician is liable for damages. Sometimes, though, "special defenses"' may be raised to absolve the physician even though it appears all the elements for malpractice are present. An example would be if a physician stopped by the roadway to help an injured victim. Even if malpractice occurred, the physician would likely not be held liable by using the special defense of Good Samaritan. Let's look at other defenses that can be utilized in court.

The following is a true scenario. An obstetrician is brought before a QA committee after being reported by a nurse. During difficult deliveries, the physician was observed pulling on the infant's hair to facilitate traction. The committee felt the physician: Had a duty; breached the duty (no OB doctor had done this painful maneuver or heard of it being done); and caused harm with the painful technique. The physician stated she had used this technique successfully many times, but the committee felt this was clear malpractice. Is there a legal defense that can be used?

Clinical Innovation Defense

A radiologist needed to get a contrast study in a child but was unable to get IV access. So he injected contrast into the child's calf and completed the study. Later, the child developed shortening of the Achilles tendon. It required two surgeries and bracing to correct. A suit for malpractice was filed, claiming that the physician had "experimented" on the child. The radiologist claimed that articles had cautioned against injecting into the buttocks or thighs, and that he had used the technique successfully many times in the past. The court did not allow the claim of experimentation and stated, "The everyday practice of medicine involves constant judgmental decisions by physicians as they move from one patient to another…"[1]

Of course, in this day and age, relying on this defense regularly would likely expose the practitioner to great risk.

Respectable Minority Defense

A patient presented to a neurosurgeon and was diagnosed with cerebral vascular insufficiency and prescribed a female hormone, estrogen. The patient developed enlarged breasts and loss of libido and brought suit against the physician. The neurosurgeon was the only one of nine neurosurgeons in Nashville to prescribe estrogen for this condition, although other physicians on the West Coast did so. The court directed a verdict for the physician stating, "[W]here there are two or more schools of thought among competent members of the medical profession concerning proper medical treatment for a given ailment, each of which is supported by responsible medial authority, it is not malpractice to be among the minority."[2]

The respectable minority defense cannot be used if a physician is the only one to practice a certain way. A corollary to the respectable minority defense is the "honest error in judgment" defense. This states that, "A doctor is not negligent simply because his or her efforts prove unsuccessful. The fact a doctor may have chosen a method of treatment that later proves to be unsuccessful is not negligence if the treatment chosen was an accepted treatment on the basis of the information available to the doctor at the time a choice had to be made."[3] This defense often applies to emergency medicine, which is constantly faced with choices of medical treatments, antibiotics, test-ordering, and disposition decisions that must be made immediately and allow for second-guessing at a later time.

Contributory Negligence

An Rh-negative woman became sensitized when no Rhogam was given after a miscarriage. She brought suit as she would have great difficulty bearing a child in the future. During trial, evidence revealed that she knew she was Rh negative, and had received Rhogam in the past, but did not tell her physician. The court ruled that her "wanton negligence" (by not telling) was a cause of the bad outcome and she was not allowed to recover damages.[4]

The legal concept of contributory negligence was first introduced in 1809 in *Butterfield v Forrester.*[5] A man who was riding his horse was knocked off it after hitting a pole. The pole had been placed across the road by the defendant. At trial it was proven that the pole could have been seen from 100 yards and that the man was riding his horse extremely fast. He would have had time to stop and avoid the pole if he wasn't riding so fast. The judge instructed the jury that if a person riding in a reasonable manner could have avoided the accident, then they should find for the defendant. A plaintiff should not be allowed to recover when they themselves are a cause of the injury. In the United States, the Restatement (Second) of Torts defines contributory negligence as "conduct on the part of the plaintiff which falls below the standard to which he should conform for his own protection, and which is a legally contributing cause cooperating with the

negligence of the defendant in bringing about the plaintiff's harm."[6]

One classic legal case directly relates to follow-up of studies. In *Ray v Wagner*, a woman had a pap smear done by her physician. The result was positive, but the physician was unable to contact her for five months, during which her cancer had greatly progressed. The patient had given false information and there was no phone at the address she listed and she did not live at the address where she had a phone. She brought suit against the physician but it was dismissed based on contributory negligence.[7] Contributory negligence completely bars recovery, with few exceptions. The courts have found that it tends to be inherently unfair, with the reasoning that if all of us had to bear the consequences of lifestyle and choices, then very few would be allowed to recover any damages. Thus, the concept of contributory negligence has generally been replaced in most jurisdictions by the concept of comparative fault. Only five states recognize contributory negligence and bar the patient from recovery if they are at all at fault.

Comparative Fault

Contributory negligence bars any recovery by the plaintiff. Comparative fault, however, allows a plaintiff to recover some damages, but they are reduced by the amount of fault that the plaintiff bears. The vast majority of states have adopted this concept into law.

For example, a patient sues a physician for malpractice. At trial, it is determined that the patient was 60% at fault. The jury awards $100,000. Pure comparative fault will reduce the award by 60%, as that was the amount that the patient was at fault, and only give the $40,000 (40%) that was determined to be directly the fault of the physician's malpractice. A real example of this concept is found in *Cox v Lesko*.[8] In this case, a physician performed shoulder surgery for subluxation. The patient then missed months of physical therapy that was ordered to strengthen muscles and improve range of motion. She then brought suit against the physician because her condition didn't improve. The judge instructed the jury to consider the patient's non-compliance to be considered under the concept of comparative negligence. Pure comparative fault is acknowledged in 13 states.

It can be seen how this defense applies to many ED situations. Often, patients don't provide critical information, take their medicine as prescribed, or comply with treatment recommendations or follow-up directions. If there is a bad outcome, contributory negligence or comparative fault can be used in defense.

Sudden Emergency

The next case has a sound legal basis, and was very imaginative. Kimberly Ross went to the ED with a lacerated finger. It was determined that sutures would be needed, and lidocaine was injected into the wound by the physician, who was in training. Immediately after the injection, Ross said she didn't feel well. Her arm jerked and her eyes rolled back. The physician walked a few feet from the bedside to summon help. Ross continued jerking and fell to the floor, hitting her head. After her fall, Ross suffered from problems with memory and dexterity and had personality changes. She was diagnosed with a vasovagal reaction and traumatic brain injury. She brought suit for malpractice. Ross claimed that the physician should not have left her side, allowing her to fall.

On initial impression, this case seems to fit the criteria for malpractice. The physician used the "sudden emergency" (in the emergency room) defense and was exonerated. This is a true defensive doctrine that is accepted in law.

The sudden emergency doctrine was derived by the courts to acknowledge that a person confronted with sudden or unexpected situation that demands immediate action may not use the same degree of judgment as they would use in normal circumstances. An example would be in a car accident, where someone is suddenly struck. They may then attempt to hit the brake pedal but hit the gas pedal instead, and thus accelerate, striking another car. That driver could claim that the sudden emergency caused him to do something he would not normally do, and the driver would likely be absolved.[10]

Summary

An ED physician, when charged with malpractice, may appear to have committed the four elements that would allow for losing the suit. There are a variety of special defenses that courts have acknowledged to trump a basic malpractice action. It is important to be aware of these defenses so they can be readily utilized if the situation arises.

References

1. Brook v St. John's Hickey Memorial Hospital, Supreme Court of Indiana, 1978. 269 Ind. 270, 380 N.E.2d 72
2. Chumbler v McClure, United States Court of Appeals, Sixth Circuit, 1974. 505 F.2d 489.
3. Ouellette v Subak, 391 N.W.2d 810 (Minn.1986).
4. In Graham v Keuchel, 847 P.2d 342 (Oklahoma 1993).
5. Butterfield v. Forrester, 11 East. 60, 103 Eng. Rep. 926 (K.B. 1809)
6. Restatement (Second) of Torts, Section 463-496
7. Ray v Wagner, 286 Minn. 354, 176 N. W.2d 101, 104 (1970)
8. Cox v Lesko, 263 Kan. 805, 953 P.2d 1033 (Kan.1998)
9. Ross v Vanderbilt University Medical Center, No.M1999-02644-COA-R3-CV,Feb. 18, 2000.
10. W.P. Keeton,D. Dobbs, R.Keeton and D. Owen, Prosser and Keeton on the Law of Torts Sec 33, at 196 (5th ed. 1984)

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meaning if the defendant was not more than 50% responsible for the injury, there is no liability.

"This happens much less frequently on standard of care issues, because the dispute is over whether the defendant provided reasonable care. This is usually more a matter of opinion," says DeMeo.

Who can be an "expert"?

Statutes and case law vary from state to state on the requirements for experts in medical malpractice cases. Most states, however, says Crider, require the expert to be qualified in the specialty of the defendant doctor.

In addition, some states have a "locality rule" which requires the physician expert to be licensed in the state or a contiguous state and to be familiar with the standard of care in the locality.

"In other words, an ED physician in a rural hospital might not be expected to follow the same course of action as a physician in a large metropolitan hospital with different resources available," says Crider. Experts can be excluded for failure to comply with the standard in the locality.

Attacking the credentials and qualifications of experts "is done often in cases," says Stimmel. "If the plaintiff's expert has no or minimal experience in an ED, we would argue they were not qualified."

However, the plaintiff may argue that their expert is qualified in the examination and diagnosis of patients, leaving it up to the judge to decide.

An expert witness must be sufficiently qualified in emergency medicine to offer testimony against the defendant-physician, says **Joseph J. Feltes,** a partner with Canton, OH-based Buckingham, Doolittle & Burroughs. "This may involve experience working in an ED or extensive work with ED physicians."

Furthermore, if the claim involves a particular procedure or the administration of particular medication, the expert must have sufficient experience with that procedure or medication. "If an expert offers testimony that goes beyond his area of expertise, his testimony will usually be stricken," says Feltes.

DeMeo says that it is not at all unusual for a plaintiff to rely on a physician who does not practice emergency medicine. "The defense response is a matter of degree," he says.

DeMeo says that in every case, the non-emergency medicine expert's credibility can and should be attacked for purposes of diminishing the impact of his/her opinion for a jury.

"The experts may try to bolster their credibility by explaining they "take call" in the ED," says DeMeo. "These claims should be scrutinized carefully to see exactly how much real experience the witness has."

In extreme cases, lack of credibility can result in the expert being stricken by the court. "Unfortunately for ED physicians, the deliberately broad-based nature of their specialty usually prevents these extreme situations," says DeMeo.

Most courts will analyze the issue from the perspective of the patient's condition, more than the setting of care. "Thus, if the expert is qualified with respect to the patient's condition, then he or she will be allowed to testify," says DeMeo.

For example, a cardiologist may be able to testify in a heart attack or aortic aneurysm case, an orthopedic surgeon or neurosurgeon may be able to testify in a trauma case, or an infectious disease physician may be able to testify in a sepsis case.

When this occurs, however, there are ways to use these specialized backgrounds against the expert. DeMeo explains that the highly specialized nature of a non-emergency medicine expert's practice can be used to paint them as an "armchair quarterback" relying on subtle signs and symptoms which may or may not have been pertinent to the patient's stabilization during the encounter.

"This argument is helped by explaining the nature of emergency medicine as often the beginning, not the end, of the medical care, as well as by good consults and discharge instructions by the ED physician," says DeMeo. "Many times, such experts are office-based with scheduled appointments. As such, the exigencies of the emergency setting can be used to show the expert is being hyper-technical or hyper-critical."

If the care at issue occurred in a high-level trauma center, that care setting may also impact the credibility of emergency medicine experts who may not deal with the

Sources

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same volume or acuity.

Interestingly, however, in some cases it may actually be to the advantage of an ED defendant to have an expert against them that is not experienced in the ED.

"We know the primary focus of an ED is very different from an examination done in another environment," explains Stimmel. "We may want a 'weak' expert against us if we have a strong, ED experienced expert on our side. We could argue at trial that the plaintiff's expert's opinions are weakened, since they have no hands-on experience in an ED."

An expert isn't allowed to use 20/20 hindsight when reviewing an ED patient's care--he or she must put themselves in the shoes of the physician, and determine whether the physician acted properly based on the knowledge the physician had at the time.

"Plaintiff experts often attempt to avoid this by looking solely at the outcome and the results of later tests in testifying that an ED physician should have diagnosed a particular condition," says Feltes.

It's also important to note, says Feltes, that the standard of care is not what a particular expert would do in a given situation, but instead what a reasonable physician would do in like circumstances.

Some experts will testify as to what they would have done in a particular situation, instead of what the standard of care requires.

"Given the many different potential methods of treatment available for ED patients, a plaintiff must prove that the treatment prescribed was below the standard of care, not simply that the patient's expert would have done it another way," says Feltes.

In many cases, the physicians and other healthcare professionals sued or otherwise involved in the case can qualify as experts. "This has benefits for the defense, because the lawyer can learn the medicine directly from the client without having to engage outside consultants," says DeMeo.

The downside, of course, is that the client's personal involvement in the case can shade his or her perspective on issues like standard of care.

"This is particularly true with respect to jury perception. A typical juror will expect a physician defendant to deny negligence even in questionable cases," says DeMeo. "Nevertheless, the client-healthcare provider is always one of the most important experts in the case."

Need an expert witness? Here's what to look for

Every trial usually comes down to a "battle of the experts," with the jury judging the credibility of the experts and making their decision. Consider these important factors, advises **Linda M. Stimmel,** a partner with the Dallas, TX-based law firm of Stewart Stimmel: Experience, education, training, the effectiveness of how the expert communicates with the jurors, and the bedside manner of the expert. "Even how the expert is dressed may affect their credibility."

The plaintiff's expert will testify that the doctor breached the standard of care and that the breach caused injury or death-the defendant's expert will disagree. "That is when the jury has to decide which expert is more believable," says **Christy Tosh Crider**, a shareholder at Nashville, TN-based Baker, Donelson, Bearman, Caldwell & Berkowitz.

When choosing an expert, it is important to consider what your jury will likely look like and their likely level of education. "The best experts strike a perfect balance of a complete command of the medicine, with an ability to explain at the level of the least sophisticated juror," says Crider.

His or her delivery, says Crider, should have the jury thinking "I like her. I trust her. I understand what she is saying. I would like her to be my doctor."

"Credentials are important, but in my opinion, not as important as the ability to deliver on the stand and to stand up to cross examination," says Crider.

The best expert witness, says **Chris DeMeo**, a health care attorney at McGlinchey Stafford, PLLC, in Houston, TX, is "someone who is not just going to tell you what you want to hear, who does not need to be spoon-fed, but can review the pertinent materials and help develop the defense theory, and can articulate the medicine and theory of the case at layman's level."

"Published experts are also nice, especially in cases dealing with a specific medical issue that is case determinative," says DeMeo. "Too much publication can be problematic, however, when it makes the witness look like an academic in situations when clinical orientation is more appropriate, or when the lawsuit opinion is different from the publication's."

It's essential that the medical concerns that need to be addressed fall within the expert's specific area of expertise. "If not, the expert may be able to suggest to the attorney a different expert or area of expertise that may be needed," says **Emory Petrack, MD, FAAP, FACEP**, president of Cleveland, OH-based Petrack Consulting.

For example, if an attorney contacts an expert about a missed testicular torsion in the ED, an ED expert should be able to review care in the ED, but if questions come up about potential loss of fertility and other sequelae, those questions might be better answered by a urology expert.

Your expert should be able to provide an unbiased, objective review of the case. "This is absolutely essential," says Petrack. "The expert is there to provide objective information as to whether the standard of care was met."

For the plaintiff's attorney, this honest, objective information is essential. If the standard of care was met and the case does not have merit, the attorney needs this information as early as possible, to make an informed decision as to whether the case is worth investing time and resources.

For the defense attorney, early information can help the defense counsel to begin structuring their strategy by understanding if standard of care was breached and settlement needs to be considered, or whether standard of care was met, perhaps suggesting that early settlement is less appropriate.

Petrack says that generally, a board certified emergency physician with an appropriate clinical background should be able to offer appropriate expert review for most ED cases.

"For pediatric patients, a board-certified pediatric emergency physician offers additional credentials and background to strengthen the credibility of the expert's findings," says Petrack.

Despite the fact that an expert review should be unbiased, there are times when there are legitimate differences in perspective and different findings in the reviews of experts, adds Petrack.

"The reality is that communication skills are an important part of the process," says Petrack. "The expert who is calm, clear and confident in their delivery, whether at deposition or trial, will have more credibility that one who is rambling or unclear in communicating their findings."

Time-dependent treatments give rise to ED lawsuits

(Editor's Note: This is the second of a two-part series on delayed diagnoses in the ED. This month, we report on legal risks involving time-dependent medications and interventions.)

Time-dependent therapies such as thrombolytics are potentially life-saving for ED patients, but the need to administer treatments within a specific timeframe increases liability risks for the emergency physician.

"Looking back over the last decade, one would have to say that the numbers of suits for delays have increased," says **John Burton, MD**, residency program director for the Department of Emergency Medicine at Albany (NY) Medical Center. Burton says that this is primarily a result of the advancement of a number of therapies that have a brief "time window" to be effective—for example, revascularization therapies for acute myocardial infarction and stroke.

"As these therapies have been introduced into mainstream practice, they've introduced issues of standard of care with patients and their eligibility that commonly enter the ED physician's purview," says Burton.

Examples of scenarios leading to an allegation of delayed diagnosis include an acute myocardial infarction that goes unrecognized at triage, or a patient experiencing early symptoms of stroke which go unrecognized until the patient is outside the treatment window for thrombolysis.

Specialty organizations and expert panels, for example, have released numerous guidelines that have promoted acute stroke therapy very aggressively, "often without rendering due accord to the question of whether this therapy is indeed effective," says Burton.

"The mainstream media has further exacerbated the potential for failed expectations with reports that sensationalize acute stroke thrombolytic therapy and characterize recovery as near miraculous," says Burton. "Given these events in the last decade, and assuming that there will be no significant changes in the structure of medicine and therapeutic regimes, it would seem reasonable to assume that these types of suits will continue to increase."

ED physician often solely responsible

With time-dependent therapies, an emergency physician must make the diagnosis rapidly on the first encounter, due to the opportunity to give a medication or therapy that has a certain 'time window' for effective therapy and patient outcome.

Burton says that in his experience, the ED physician's legal exposure is much greater with these scenarios, than for cases involving delayed diagnosis of conditions that don't have an immediate impact on the patient's outcome.

"Diagnosis delay with a time-dependent therapy is typically a single emergency encounter, where the circumstances revolve around this sole encounter," Burton says. The jury will answer the question: Was the ED physician negligent for missing or delaying the diagnosis, such that the patient could no longer derive the benefits for a therapy or medication for which they would have been eligible with prompt diagnosis?

"In these circumstances, the case is pretty tidy. The emergency physician is often the only physician whose judgment and actions are under question," says Burton. "There is a tight time window, on the order of hours,

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necessitating the importance of prompt diagnosis and prompt therapy."

While many experts continue to debate the merits of this time-dependent therapy in acute stroke, says Burton, "there certainly is no debate regarding antibiotic therapy for meningitis or revascularization for acute myocardial infarction."

"In these examples, the emergency physician is sued for a delay to diagnosis that translated in an immediate and tangible issue: The loss of an opportunity for treatment with an effective medical therapy," says Burton.

Review these ED processes

To reduce risks, Burton says that high profile, time-dependent therapies should routinely be subjected to a "process review" in each ED. Burton says that these reviews should involve physicians, nursing staff and leadership, hospital administrators, and possibly consultants, in order to "consider all elements of these potential encounters."

Burton says to examine these processes:

- Triage protocols for conditions such as chest pain or weakness;
- Time-dependent testing processes, including door-to-electrocardiogram time for chest pain patients and computerized tomography scan accessibility for stroke;
- Medication administration processes, including availability of antibiotics and thrombolytics;
- Participation of consultants such as neurologists and cardiologists.

"Simultaneously, working groups should be formed to create similar processes when new therapies or treatments are integrated into practice—hypothermia for post-cardiac arrest patients, for example," says Burton.

Clinically significant delays on the order of hours can be prevented through triage protocols, to ensure that patients with potentially time-sensitive diseases are identified immediately, says **Jesse M. Pines, MD, MBA, MSCE,** assistant professor of emergency medicine and epidemiology at the Hospital of the University of Pennsylvania in Philadelphia. For example, patients with chest pain would receive expedited work-ups and electrocardiograms within 10 minutes to prevent delays for a possible acute myocardial infarction, and meningitis patients would be treated empirically with antibiotics.

"The other way to reduce the likelihood of delays on the order of hours is to put more resources into the ED—hiring more staff and adding space, such that patients are not made to wait long periods for testing and treatment," says Pines.

CNE/CME Instructions

Physicians and nurses participate in this CNE/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*

17. What type of negligence might be found when a patient's own conduct plays a role in causing harm to himself or herself?
    A. Contributory negligence
    B. Comparative fault
    C. Sudden emergency
    D. Both A and B

18. Which is recommended regarding the timing of involving expert witnesses if an ED physician receives a request for the medical record from a plaintiff's attorney?
    A. Experts should not be hired by the ED physician to review the patient's chart until the lawsuit has actually been filed.
    B. An ED physician's own experts could potentially convince a plaintiff to drop a weak case early in the process, especially if there is a clearcut medical defense to causation based on the timing of the presentation to the ED.
    C. The defense should use the deadlines set by the court to disclose expert witnesses for overall case management, without involving experts any sooner.
    D. It is not possible for the ED's attorney to provide an opinion by their own expert to try to convince the plaintiff to drop their claim.

19. Which of the following is true about requirements for experts in a lawsuit alleging medical malpractice by an ED physician?
    A. No states require physician experts to be familiar with the standard of care in the specific locality.
    B. A cardiologist would not be allowed to testify in a

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. ■

heart attack case involving care given in an ED.

C. An expert's review of an ED physician's care cannot be retrospective in nature, such as determining whether the physician acted properly based on the results of later tests.

D. If an expert says they would prescribe treatment differently than the ED physician, that alone is sufficient to show that the standard of care was breached.

20. Which is true regarding risks of delayed diagnoses on the order of hours in the ED?

A. The increase of time-dependent therapies such as thrombolytics in no way increases liability risks for emergency physicians.

B. Triage protocols with expedited work-ups and electrocardiograms for chest pain patients should not be utilized, as these have not been shown to reduce liability risks.

C. An ED's time-dependent testing processes, including door-to-electrocardiogram time for chest pain patients and computerized tomography scan accessibility for stroke, should be routinely reviewed.

D. The ED physician's legal exposure for cases involving time-dependent interventions is no greater than legal exposure for cases involving delayed diagnosis of conditions that don't have an immediate impact on the patient's outcome.

Answers: 17. D, 18. B, 19. C, 20 C.