ED Legal Letter™

Special Supplement: H1N1: Anatomy of an Outbreak

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'Against Medical Advice' in the ED: Where We Are in 2009

*By **Edward Monico, MD, JD**, Department of Surgery, Section of Emergency Medicine, Yale University School of Medicine.*

Introduction

In light of the existing health care crisis, patients who leave the emergency department (ED) against medical advice (AMA) will foreseeably represent an increasing population of emergency patients. Despite this, these patients have attracted little academic interest within the emergency medicine literature. Also, confusion persists among emergency medicine physicians regarding what safeguards to use to protect both patients and physicians from adverse medical and legal ramifications associated with this disposition. This article discusses the relevant issues surrounding AMA patients that exist to date, including terminology, the origin and source of physician obligation, a review of extant AMA literature, liability, outcome, and documentation.

Terminology

No cogent discussion about AMA dispositions can proceed without first attempting to whittle down what is meant by the term "against medical advice." Health care providers and scholars invoke the phrase in practice and in the literature to describe an expanse of clinical encounters where a patient's decision causes a therapeutic or diagnostic goal to fall short of the provider's expectation. Both provider and scholar apply these three words like grammatical duct tape over an expanse of broken clinical scenarios in need of repair. Health care providers frequently use "AMA" even when the facts contradict the term's simplest conveyance. For instance, medical students, interns, and the occasional seasoned attending sees fit to describe patients who leave the ED waiting area without being seen as leaving "against medical advice" despite the fact that advice had never been rendered. On the other hand, academic scholars writing about AMA dispositions: limit the discussion to describe the timeliness of discharge,[1] distinguish patients who leave AMA from patients who leave without being seen (LWBS) or complete their ED care,[2] or simply never attempt to define the term at all.[3]

Legal and ethical obligations

The standard against which physicians are measured when confronted with a patient who wishes to leave AMA has developed apart from medicine's typical evolutionary course for standard of care. When it comes to AMA dispositions, the medical profes-

sion has departed from the typical self-regulation and scientific scrutiny characteristic of medical science. First, physicians have largely allowed other professions, political entities and legal standards to define physician obligations for AMA encounters. Second, to the extent that the medical community has defined any disclosure standard, it is based upon professional consensus and custom, not an objective analysis of patients' informational needs.[4]

The origin of the informed consent doctrine that underlies a patient's right to refuse treatment is found in the intentional tort of battery. Under this rubric, failure to obtain informed consent constituted an unlawful touching because the physician was limited by the consent given.[5] In the 20th century, courts further defined and expanded informed consent doctrine to included negligence. The common thread running from tort to battery lies in the ancient Anglo-American prohibition of physical trespass and the fundamental right of every individual to determine what will be done with his or her body.[6] The American Medical Association Code of Medical Ethics has implicitly espoused this view since at least 1981:

The patient's right of self-decision can be effectively exercised only if the patient possesses enough information to enable an intelligent choice. The patient should make his or her own determination on treatment. The physician's obligation is to present the medical facts accurately to the individual responsible for the patient's care for management in accordance with good medical practice…Social policy does not accept the paternalistic view that the physician may remain silent because divulgence might prompt the patient to forego needed therapy. Rational, informed patients should not be expected to act uniformly, even under similar circumstances, in agreeing to or refusing treatment.

The American College of Physicians and the American Society of Internal Medicine also endorse this view.[7]

Courts have recognized a fundamental common law right of a competent adult to refuse medical treatment.[8] In some jurisdictions, the state's recognition of that right is particularly strong. For instance, in New York the common law right to refuse medical treatment has been codified in the legislature.[9] Furthermore, the court in *Fosmire* declared the "fundamental common-law right is coextensive with the patient's liberty interest protected by the due process clause of our State Constitution."[10] Generally, this right is subject only to the state's compelling and overriding interest to preserve life, prevent suicide, protect innocent third parties, and preserve the medical profession's ethical integrity.[11]

In addition to drawing from the common law and various state constitutions, courts have found patients' rights to refuse medical treatment to stem from the federal Constitution, as well. Although the U.S. Constitution contains no provisions expressly setting forth a constitutional right to refuse medial therapy, recent federal cases have found such a right implied within the more general constitutional protections embodied in the Fifth and 14th amendments. The derivation of a patient's constitutional right to refuse medical intervention arises from several fundamental guarantees which create a penumbral right to individual privacy and liberty that is no less important than the rights specifically articulated in the Constitution.[12] For instance, the court in *Satz v. Permlutter* grounded the right of a terminally ill, elderly patient to refuse life-sustaining treatment in a constitutional right to privacy. The United States Supreme Court expressed similar sentiments, but chose to ground the right to refuse medical treatment in a 14th Amendment liberty interest rather than the right in privacy.[13]

Lastly, Congress created the Emergency Medical Treatment and Actives Labor Act (EMTALA) to provide adequate emergency medical services to the indigent and uninsured who seek emergency care. EMTALA sets out an obligation that physicians must adhere to when patients refuse to consent to treatment:

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Associate Publisher: Coles McKagen
Managing Editor: Allison Weaver
Contributing Editors: Robert Bitterman, MD, JD, FACEP; and Stacey Kusterbeck.
Director of Marketing: Schandale Kornegay

Questions & Comments

Please contact **Allison Weaver,** Managing Editor, at allison.weaver@ahcmedia.com.

A hospital is deemed to meet the requirement of paragraph (1)(A) with respect to an individual if the hospital offers the individual the further medical examination and treatment described in that paragraph and informs the individual (or a person acting on the individual's behalf) of the risks and benefits to the individual of such examination and treatment, but the individual…refuses to consent to the examination and treatment.[14]

Patient and hospital characteristics

Most of the academic literature focusing on AMA dispositions isolates one frame of the overall AMA picture. For instance, some authors focus on patient characteristics, subliminally inferring there must be something about patients that want to make them leave AMA. Generally, these studies demonstrate that refusing medical care is a commonality among the socio-economically impoverished typically defined as those without insurance or covered by Medicaid. One study demonstrated how certain presenting symptoms such as nausea and vomiting (9.7%), abdominal pain (7.9%), and nonspecific chest pain (7.6%) might foreshadow an AMA disposition, but stopped short of suggesting that leaving AMA is part of the symptom complex.[2] Studies evaluating AMA discharges among hospitalized patients seem to support the lower income category prevalence, and add African American race, men, and younger age to the mix.

Other studies focus on external factors that might contribute to the decision to leave AMA. Studies that focus on hospital factors generally conclude that location in large urban areas, hospitals with a greater proportion of minorities, and hospitals with the lowest Herfindahl indices (an economic indicator of market power) somehow lend themselves to AMA discharges.[15] While overcrowding contributed to AMA discharges,[16] teaching hospitals had fewer AMA discharges when compared against non-teaching hospitals.[17] One study that remarked on the patient–physician dynamic revealed that one of the most common reasons for leaving AMA was dissatisfaction with care[18] and lack of trust in the health care provider.[19]

Taken together, these studies seem to suggest that multiple factors have their hands on the wheel steering patients toward leaving AMA. Which factor or factors predominate on any given occasion may be the product of how environmental factors influence individual circumstance. Identifying how these factors play on each other and their role in the dynamic milieu of the ED may be the only way to truly understand AMA encounters.

Physician liability in AMA encounters

Physicians' angst regarding their liability arising out of AMA encounters may be well founded. These patients sue the physician and hospital nearly 10 times as often as the typical ED patient, yielding a rate of about one in 300 AMA cases versus the usual rate of one in 20,000–30,000 ED visits.[20] Physician misconceptions about AMA encounters may be one factor that contributes to AMA litigation risk. For example, belief that providing patients leaving AMA with aftercare resources in the form of discharge instructions exposes physicians or institutions to greater liability is one such misconception. In fact, aftercare instructions may decrease AMA liability.[21] The ability of a patient's signature on an AMA form to confer legal immunity to the physician is another common misconception. Physicians who discharge patients AMA enjoy no definitive legal protection from the consequences of their patients' choices.[22] This is due, in part, to failure to adequately adhere to and document AMA protocols. In a 2008 presentation to the American College of Emergency Physicians (ACEP),[20] Dr. Robert Bitterman stated the most common failures included:

- Failure to adequately document that the patient couldn't be found or left of his or her own free will prior to the medical screening examination;
- Failure to insist that the patient sign the AMA form, and instead discharged the patient without first documenting the patient's refusal to follow the recommended treatment plan;
- Failure to adequately inform the patient of the risks of leaving which are specific to the patient's chief complaint.

In general, a physician's liability may hinge on whether there was a duty to commit the patient to the hospital involuntarily or release him AMA. A second wave of rulings may turn on the sufficiency of the information exchange and how it is reflected in the medical record. Demonstrating in the medical record that the patient's ability to make an informed decision was done in a competent manner with sufficient information to make such a decision puts the physician in the best possible position to defend a claim of medical malpractice. This is done under the caveat that the patient is not a clear danger to himself or others, nor is unable to care for himself.

AMA outcomes

There is a paucity of outcome data dedicated to patients who leave the ED AMA. One reason for this is that outcome data require a return visit and re-evaluation — two events that do not seem to occur with AMA patients in a statistically meaningful way. The scarcity of return visits maybe due to patient belief that resolution of symptoms negates the need for further follow-up and that the decision to leave AMA will invoke derision from staff members.[23] Also, attempts to track these patients have proved difficult.[24] Other impediments to learning the fate of AMA patients include the fact that most of the AMA literature is comprised of studies that are either small,[25] include single-

site settings,[26] or focus on specific medical subpopulations such as patients suffering from asthma.[27]

One study concluded that AMA patients have a higher number of rehospitalization rates and more severe symptoms at the time of discharge.[28] A similar study demonstrated that during a 30-day follow-up period, patients who left AMA had significantly more emergent hospitalization and ED visit rates compared with control groups.[29] What these studies suggest is that the prognosis of patients who leave emergency services AMA falls statistically between patients who consent to admission and those for whom admission is not recommended.[30] What this means for non-statisticians is that patients with asthma, for instance, who left AMA were more likely to have an asthma relapse within 30 days resulting in higher revisits and readmission to the hospital when compared to other discharged patients.[27]

AMA documentation

Curiously, the liability risks AMA disposition represent to emergency physicians have not translated into a universal understanding of how to document the interaction between the physician and the patient leaving AMA. An amazing amount of ambiguity persists regarding what to tell patients and what to memorialize in the medical record. Inadequate documentation may actually increase the likelihood of proving liability against the provider when an invalid AMA is obtained and no care is provided. The sobering reality remains that even in the presence of a valid AMA, the question of liability may be more dependent on the expertise of legal counsel than on the facts. However, to put themselves in the best possible position to defend a claim of medical malpractice, physicians should have sufficient understanding of what contents constitute the medicolegal floor in AMA documentation. Generally, it should be said that most hospital AMA forms contemplate some or all of the following (or more) would be documented in the narrative space provided on the document. Simply signing the blank form, in my opinion, amounts to signing a blank check if a claim of malpractice follows.

A threshold question may be if the patient possesses the competence and capacity to make medical decisions concerning health care. Simply stating the patient "understood" may be difficult to substantiate in court. Instead, physicians should document the patient's ability to provide a lucid history, reasoning, and exam findings such as Glasgow coma scores that contribute to assertions of competence and capacity. The lack of mitigating factors such as alcohol and distracting injury should also be acknowledged.

Second, physicians must document that the patient was informed of the extent and limitation of the evaluation conducted up to the point the patient expressed the desire to leave AMA. For instance, documentation that a patient was informed that a negative electrocardiogram and cardiac enzymes does not conclusively eliminate the possibility of an acute coronary syndrome would be of paramount importance when chest pain patients refuse further evaluation for that symptom.

Documentation should also reflect that the patient and physician were on the same page during discussions of the presenting signs and symptoms and that the patient was made aware of the specific concerns the physician had regarding the presentation.

Demonstrating that the patient was made aware of the risks of not receiving treatment is the next factor. This would include, for example, death from chest pain that the physician thought might represent unstable angina. Other required documentation includes enumerating reasonably foreseeable complications, such as worsening asthma resulting in the need for prolonged hospitalization.

Alternatives, if they exist, should be discussed and documented. Prolonged observation in the ED or an observation center would be typical examples of alternatives to leaving AMA.

It should be explicitly stated that the patient left AMA as well as what specific care and treatment were refused. Simply writing the words "patient refused care" may be legally insufficient and construed as a conclusion without the contextual reference of what care was refused.[31]

Lastly, the AMA note should contain that patients were provided the opportunity to ask questions, timely follow-up was provided, and discharge instructions containing this information were given to the patient.

Conclusion

Patients who leave the ED AMA may represent an increasing liability risk to emergency medicine physicians in light of the current health care crisis and the burden that crisis places on emergency care. Acknowledging this population through increased academic interest, self preservation, or both, is needed to enable the medical community to better understand what these patients mean in terms of health care risk and liability potential.

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In danger of being sued? Don't go into denial

Take action before the lawsuit is filed

If it ever happens to you, it's a moment you'll never forget—being served with papers from a patient's attorney. What do you do first?

Actually, the time to take action is before you are sued. According to **Justin Greenfelder**, an associate attorney in Canton, OH-based Buckingham, Doolittle & Burroughs, ED physicians need to recognize the warning signs that point toward a lawsuit potentially being filed. These include an unexpected clinical outcome, delayed diagnosis or treatment, equipment failure, or an angry patient or family member.

"Obviously, this is not an exact science," Greenfelder acknowledges. "Bad outcomes don't always result in lawsuits, and heroic efforts sometimes go punished."

Instead of going into denial if you suspect you may be sued, Greenfelder says that you should take these steps:

1. Review the medical record to make sure that it is timely, accurate, and complete.
2. Contact your group's insurance carrier to put it on notice.
3. Consider discussing the potential suit with the hospital's risk manager or legal counsel, since the hospital also may be involved as a defendant. "However, the advisability of doing so should be a joint decision made by the physician and the group's legal counsel," says Greenfelder.

Jill M. Steinberg, a shareholder at Memphis, TN-based Baker, Donelson, Bearman, Caldwell & Berkowitz, P.C., recommends that any ED physician who believes that he or she is about to be sued should immediately inform the insurance company of a potential claim.

"If indeed the physician has committed malpractice, there might be an opportunity to settle a matter early without suit being filed," says Steinberg. If the physician does not have any concerns regarding care, then an insurance company lawyer will be able to give advice or reassurance.

However, she adds, resist any urge to blame other caregivers for any adverse result that occurred. Often, once a suit is filed, all of the caregivers will be sued. "Thus, telling a patient that they have a claim against another doctor or hospital may come back to haunt the doctor," says Steinberg.

Resist urge to add to your documentation

Joseph J. Feltes, a partner with Buckingham, Doolittle & Burroughs, says that a good, contemporaneously-prepared medical record is the best defense. "There may be times, shortly after treatment in the ED, that the ED physician may want to add a clarifying addendum," he notes.

However, it is important that the addendum be dated when it actually was written and not, under any circumstances, be backdated to make it appear that it had been

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Of Tourniquets and Arbitrations

*By **Jonathan D. Lawrence, MD, JD, FACEP,** Emergency Physician, St. Mary Medical Center, Long Beach, CA; Assistant Professor of Medicine, Department of Emergency Medicine, Harbor/UCLA Medical Center, Torrance, CA.*

A recently arbitrated case presents a starting off point for a discussion regarding a commonly applied dressing and a frequently used but often misunderstood method of resolving medial malpractice disputes.

On November 11, 2006 a 10-year-old girl accidentally closed a car door onto her left (non-dominant) small finger. Her mother brought her to the emergency department, where she was seen by a nurse practitioner supervised by the attending emergency physician. On exam, a superficial laceration was noted at the distal inter-phalangeal joint. Motor, sensory, and vascular functions were normal. An x-ray was obtained that showed no fracture. The wound was dressed with some Neosporin® and a tube gauze. Her mother was instructed to return in three days for a wound check, which she did. The mother had removed the dressing prior to the recheck because the child complained of pain to the digit. On exam, the distal finger appeared necrotic and the child was referred to hand surgery. The distal phalanx was eventually amputated after it demarcated. The mother complained that the tube gauze was applied too tightly to her daughter's finger, causing the loss of part of her finger, and she brought legal action against her health plan. As a condition for joining this health plan, the mother had agreed that all contentions of medical malpractice be adjudicated by binding arbitration. Binding arbitration was held and the arbitrator found for the patient, awarding her monetary damages.

The Bandage

As often as tube gauze is applied to digits, there are only a handful of case reports that claim its use resulted in necrosis of a finger.[1-5] This must mean that complications of its use occur extraordinarily rarely. The bandaging has been available without prescription for decades at any pharmacy. It has always been considered a useful adjunct to wound care as it effectively and securely covers wounds, protects them, and at the same time, in the case of digits, immobilizes the affected part. As a downside, the finger, including its tip, is completely covered, precluding inspection. As far as I know, there has never been a product liability case brought by the plaintiff's bar against any manufacturer for producing an unreasonably dangerous product, or defective instructions or warnings on its use. (The basic elements of a product liability case)

The case reports cited try to explain these poor outcomes by a number of theories, none of which have been proven. One theory is misapplication of the bandage, creating a tourniquet on the digit, thus cutting off blood flow leading to ischemia and necrosis. The main problem with this theory is that ischemic digits, as with ischemia anywhere, are likely to be extremely painful, causing either the patient to either seek immediate medical attention or remove the bandage, or both. Also, it is extremely difficult to misapply the tubular gauze in a way that causes a tourniquet. Another theory is the "Chinese Finger Trap" theory. Since these tube gauze dressings are woven and stretchable, the theory goes, a misapplied dressing with any traction will apply pressure forces on the digit beyond arterial pressure and cause ischemia. Again, the primary problem is the lack of reported cases, either medical or legal, compared to the millions of applications of the product. Most of the applications are not done in medical settings, thus the number of times the gauze is stretched during its application must be countless, and one would expect more frequent problems.

A far more likely explanation is that there is something inherently wrong with the vasculature of these reported cases. In of one of the reported cases, the victim was a 74-year-old woman with hypertension, diabetes, hyperlipidemia, and a history of smoking, all of which put her at increased risk of distal ischemia. The 10-year-old in the present case had traumatized her finger in a car door, with a likelihood of arterial injury despite a benign outward appearance of the digit. It would be hard to prove that the dressing and not the original injury caused the eventual ischemia and amputation.

The take-home message of these rare cases is that practitioners should continue to use this useful dressing under appropriate circumstances, but patients should be informed on discharge of the circumstances upon which they should immediately return. Primarily, any increase in pain necessitates removal of the bandage and recheck of the digit. Patients possibly at higher risk of complications include children, the elderly, "special" patients such as those with Reynaud's, and those in whom long-acting digital anesthesia has been used.

The Arbitration

Arbitration, in the legal sense, is a dispute settling mechanism that is more formal than mediation (where a

mediator guides the parties to agree on a mutually acceptable solution to their conflict) and less formal than a trial. An arbitrator (or panel of arbitrators) hears the facts from both sides (termed "petitioner" and "respondent" instead of "plaintiff" and "defendant," respectively) and issues a ruling on the merits of the case.

Arbitration is used primarily under two circumstances in medical malpractice cases.

The first is court-ordered. These are usually statutory in nature and vary from state to state. When the amount of damages claimed or estimated is under a certain specified amount, the court can order the parties into arbitration to see if the dispute can be settled without using the court's limited resources for a full trial. These are uncommon in medical malpractice since the damages asked, for most part, often exceed the statutory limits. Arbitration of this sort is not binding. Either party, if dissatisfied with the result, can ask the court for a trial *de novo*, meaning a court trial as though the arbitration had never occurred. The party that asks for the trial, however, is penalized for a number of trial-related costs if they do not fare better in the trial than they did at arbitration.

Binding arbitration is the second arbitration form and far more common in the medical malpractice scenario. Usually, a patient will sign a binding arbitration agreement with a health care provider or health plan as a condition of being accepted by the plan. Under the agreement, all disputes arising out of the provision of health are sent to arbitration and the results (with few exceptions) are binding on the parties. These agreements to arbitrate are considered contracts and are subject to all the laws regarding the formation of contracts. Thus, they are legal unless, for example, one of the parties has been induced into the contract by means of fraud.

The following rules applying to binding arbitration come from California statute; other states may vary. The arbitration is usually held before a neutral arbitrator who hears the evidence presented by both parties, including expert witnesses, just as in a trial. Proof of lack of neutrality is one of the very few grounds for appealing and setting aside the arbitrator's findings. The rules of evidence are relaxed, so that evidence that might be barred in trial (such as hearsay) can be admitted by the arbitrator. The arbitrator has great latitude in allowing or disallowing evidence. Witnesses are not required to testify under oath unless requested by one of the parties. Arbitration hearings are usually not recorded, meaning there is no written record of the statements of witnesses. Once the arbitrator makes a ruling, the decision is final barring a very few specified circumstances where the arbitrator's conduct warrants setting aside the decision.

In the case of the 10-year-old presented above, the neutral arbitrator heard evidence from the patient, the health care providers, and the expert witnesses. The petitioner's case relied on expert testimony that alleged the tube gauze must have been applied too tightly, otherwise the patient would not have lost her finger. Respondent, via evidence from a hand surgeon, answered that, with evidence that the finger was crushed, petitioner had not met her burden of proof that the bandage and not the injury itself caused the ischemia. Astonishingly, the arbitrator found for the petitioner, reasoning that the health care providers didn't provide enough evidence to allow him to account for the ischemia from the original injury. Damages were awarded for pain and suffering and future prosthetics (for the distal phalanx of the non-dominant 5th finger).

Summary

Arbitration offers both sides to a dispute the opportunity to resolve the matter more quickly and less expensively than a full trial in court. Such advantages must be weighed against the more informal nature of arbitrations, including the possibility that an arbitrator may be as capricious as a jury of 12 lay persons.

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part of the record that was created contemporaneously with the treatment. "That could lead to allegations of fraud," warns Feltes.

Feltes adds that it is not advisable to create an addendum weeks or months after treatment, and it is never advisable to create an addendum after receiving notice of an intent to sue or the actual filing of a lawsuit.

"An elaborate addendum may ironically make the ED physician more susceptible to difficult questions in cross examination," explains Feltes. "Even worse, a jury may view an elaborate addendum as self-serving, which detracts from the physician's credibility."

ED physicians should not prepare personal notes, reflections, diaries, memoranda, mea culpas, or finger-

Sources

- **Joseph J. Feltes**, Buckingham, Doolittle & Burroughs, Canton, OH. Phone: (330) 491-5225. E-mail: JFeltes@BDBLAW.com.
- **Jill M. Steinberg**, Shareholder, Baker, Donelson, Bearman, Caldwell & Berkowitz, P.C., Memphis, TN. Phone: (901) 577-2234. E-mail: jsteinberg@bakerdonelson.com.

pointing in any media, including paper or computer-generated documents and e-mails. "These are not protected, are discoverable by the plaintiff's attorney, and can all be used in cross examination against the physician," says Feltes.

Upon being served either with a notice of the intent to sue, or the actual service of the summons and complaint, your first phone call should be to your malpractice insurance carrier, which at that time will likely assign you an attorney. If, in the meantime, you have questions that need immediate attention, contact your group's legal counsel.

"It also may be prudent to contact the hospital's risk manager or legal counsel, but only after consultation with the carrier's or group's attorney," says Feltes. "Conversation with the hospital's risk manager or legal counsel may not be privileged."

Don't do your own investigating

Avoid doing these three things, says Feltes: Pointing fingers at other caregivers, discussing the case with hospital personnel or colleagues, and talking directly to the patient's family after a suit is filed.

Above all, resist any temptation to conduct your own, non-privileged "investigation" by discussing the matter with colleagues or staff, either in person, by phone, or in e-mails. "These conversations often entail speculation and opinions that may not be based on the facts, and which may be discoverable by the plaintiff's attorney, who may use them to the detriment of all," warns Feltes.

"We all remember those scenes in TV crime shows where the accused is given his Miranda rights—anything that you say can and will be used against you by the other side in a court of law," says Feltes. "The same applies to non-privileged conversations."

Personal communications can be discoverable

Even incident reports aren't always protected

Your own personal notes about a patient's care. Incident reports if a patient is harmed. Information given verbally or in writing to the hospital's risk managers. Conversations or e-mails with other ED physicians about the patient's care. E-mails or conversation with physicians who don't work in your ED. Personal correspondence with non-involved parties.

All of these items are potentially discoverable, according to **Steven D. Davidson, JD**, a partner with Omaha, NE-based Baird Holm LLP. "All notes, conversations or e-mails with colleagues, whether inside or outside the ED, are typically subject to discovery," says Davidson. "The same is true for incident reports and conversations with risk management where facts about the event are being gathered."

There are two general exceptions, however. The first includes any information provided to an attorney, or to

3 Dos and Don'ts to Heed if You're Sued

According to **Ken Braxton**, a health care attorney at Dallas, TX-based Stewart Stimmel LLP, ED physicians, when notified of a possible lawsuit or claim, should avoid all of the following actions:

1. *Never alter documentation when notified of a possible lawsuit or claim.*
   "The patient's attorney probably already has the medical records, so any alteration or addendum will be immediately used to allege a cover up," says Braxton.
2. *Never call the patient or their attorney to try to talk them out of the lawsuit.*
   "This amounts to free discovery for the attorney, who will more than likely let the ED physician 'spill their guts,'" says Braxton.
3. *Never talk to other providers involved with the care to the patient without an attorney present, other than in a peer review setting.*
   Braxton cautions, "All non-peer review and non-attorney conversations with other providers are subject to discovery."

Here are three things that Braxton recommends doing if you are sued:

1. *Immediately notify your insurance carrier to get advice on how to respond upon receipt of the notice.*
2. *Tell the director of the ED, so that the medical records are secured.*
3. *Create a personal file that includes the ED physician's correspondence and lawsuit documents and a copy of the patient's chart.*

others when an attorney is present to give legal advice.

"For that reason, we often advise that a lawyer be involved promptly after a significant adverse event, so that conversations and information can be protected by the attorney/client privilege," says Davidson.

The second exception is conversations and information provided for a peer review committee.

States treat the peer review privilege differently. For example, in Nebraska, according to **Joseph J. Feltes,** a partner with Buckingham, Doolittle & Burroughs, if a physician provides information or creates documents in connection with an evaluation of the event by a formally-recognized peer review committee, which is acting within its function to evaluate and improve care, a privilege exists that protects the information from discovery in a later malpractice action involving the same event. However, again in Nebraska, this privilege does not reach incident reports or communications with risk managers who are gathering information about an event in the normal course of their job duties, and not in connection with a particular peer review activity. "This privilege does not prevent access to the underlying facts about the event, but rather the evaluative activity of the peer review committee," says Davidson.

A blood culture result comes back positive: What are your legal risks?

It's a 'screening test nightmare' for EDs

A woman tells you she's had a headache for over a week and a history of diarrhea, and develops a fever during her ED stay. The headache resolves with non-narcotic interventions, and blood cultures are obtained. The patient's chest X-ray shows streaking. She is treated with parenteral ceftriaxone for presumed pneumonia, and discharged on doxycycline.

Four blood cultures come back positive, but when an ED nurse contacts the woman's husband, he says she's doing much better. Neither the ED nurse nor the physician asks the patient to return to the ED, and she returns two days later with altered mental status and partially treated meningitis. An adverse outcome results. Could your ED be sued?

"Blood cultures continue to be frequently drawn on ED patients, and often for good reason," says **John Burton, MD**, residency program director for the department of emergency medicine at Albany (NY) Medical Center. "However, this is a very problematic test from an ED perspective."

First, the results do not come back for 24 hours, and often are not finalized for up to 48 or 72 hours. "The patient is long gone from the ED at that point, of course," says Burton. "The yield of the tests are very low, with most published reports indicating true positive cultures in as low as 1% of patients to a high of around 9%."[1-3]

Burton adds that in most studies, positive results are just as likely to be false positive contaminants as they are true positives. "The bottom line is, it's a test that does not give immediate results, and is just as likely to give bad information as it is to give information that contributes to patient management," says Burton. "In short, it is a screening test nightmare, in my opinion, for an ED test."

Every positive blood culture should be reviewed by an ED physician, to see where the culture fits into the patient's clinical picture, says **James R. Miner, MD, FACEP**, associate professor of emergency medicine at University of Minnesota Medical School and faculty physician in the ED at Hennepin County Medical Center, both in Minneapolis. "Patients with a blood culture that isn't an obvious contaminant should be contacted immediately for follow up, hopefully with their primary care provider but in the ED if it can't be arranged," says Miner.

The difficult part of ordering a test that will not yield final results while the patient is in the ED is that the ordering physician is the one responsible for acting on the findings of the results, says Miner. "If a blood culture returns positive and a patient goes untreated, the physician who ordered the blood culture is responsible for not arranging appropriate treatment," he explains.

When should patients return?

Burton notes that in 12 years of doing medical– legal cases in seven different states, he hasn't seen a single case involving failure to contact a patient with a positive blood culture obtained in the ED.

"But, it's certainly a risk," Burton says. "The risk and prevalence of cases is likely much smaller because the majority of patients with positive cultures who are also initially discharged tend to do very well. This suggests that the sicker and higher-risk patients tend to get admitted for reasons independent of any information yielded from ED blood cultures."

If a patient with a positive culture doesn't return to the ED, risks include failure to administer appropriate antibiotic coverage to a patient with bacteremia. **Edward Monico, MD, JD**, assistant professor in the section of emergency medicine at Yale University School of Medicine in New Haven, CT, notes that microorganisms that always or nearly always represent true infection when isolated from blood cultures include *Staphylococcus aureus, Streptococcus pyogenes, Streptococcus agalactiae, Streptococcus pneumoniae, Escherichia coli,* and other members of enterobacteriaceae, *pseudomonas aeruginosa*, the *Bacteroides fragilis* group, and the *Candida* species.

In contrast, coagulase-negative staphylococci, *Corynebacterium* species, *Bacillus* species other than *B. anthracis*, and *Propionibacterium acnes* usually represent contamination, says Monico. "*Corynebacterium* species are part of the normal human skin flora, so they typically do not cause true invasive disease," he says. "But *Corynebacterium* can cause clinically significant infections in the presence of medical devices such as joint prostheses, catheters, ports, vascular grafts, prosthetic heart valves, pacemakers, and implantable cardioverter defibrillators."

To notify your patient about a positive result, Burton says it is equally acceptable to contact either the patient or the primary care physician, provided that the doctor is familiar with the patient and agrees to assume responsibility for follow-up.

Whether the patient is on antibiotics as an outpatient is a factor that must be considered, as well, says Burton. However, if the patient is still having infectious disease symptoms that could be attributable to the culture, or is in a high-risk group such as an immunocompromised, elderly, or intravenous drug abuse patient, he or she should be asked to return immediately for reassessment.

"If the patient is in a high-risk group, is still having symptoms, or not on antibiotics, then the risk for not having them evaluated is substantial," says Burton. "If the answer to all these queries is in the negative, then the risk is relatively small."

According to Monico, since blood culture results do not return until the patient has been discharged from the ED, the responsible ED physician should have a strategy in place to assure the timely interpretation of these results.

Monico says that strategy should be, in the overwhelming majority of cases, to admit patients requiring blood cultures. "For the remaining few, the chart should clearly document who will be responsible for the interpretation of blood culture results in patients discharged from the ED," says Monico. "That person should be the primary care physician who agrees to accept this responsibility."

When to have the patient return to the ED is largely dependent on the context of the case, says Monico. "A positive result should be reviewed in light of the patient's chief complaint, comorbidities, ability to obtain timely follow up, and treatment rendered at the time the cultures were obtained," he says.

Make a good faith effort

Document all the efforts made to contact the patient, including phone calls to the patient's home or primary care physician's office, and certified letters sent to their mail address. "This is simply all that can be done. The ED should essentially document a 'reasonable good faith effort' to make this contact," says Burton.

Miner says that he usually makes three phone calls to the patient at different times of the day, then sends a letter asking the patient to return to the ED for reevaluation due to their positive blood culture.

How exhaustive an effort you make depends largely on your practice environment. "Policies are likely going to be different for an inner city, indigent population than a population that has a high prevalence of primary care doctors and reliable health network," says Burton.

If you reach the patient's primary care physician, document the time and content of that discussion. "This should reflect any conclusion the ED or primary care physician makes regarding whether the results represent infection or contamination and the shift of responsibility for patient follow-up," says Monico.

Monico says that your documentation should reflect the level of concern as to the likelihood of true infection versus contamination. "This documentation can involve phone calls to the patient, the patient's relatives, primary care physicians or, depending on the scenario, agencies such as the state board of health," he says.

"Risk stratify" a positive culture

Traditionally, blood cultures were typically performed in an ED only for certain types of patients suspected to have bacterial infections, notes **Matthew Rice, MD, JD, FACEP,** an ED physician with Northwest Emergency Physicians of TEAMHealth in Federal Way, WA. This group included young children with fevers of uncertain origin, the immunocompromised who might have an infectious process, and other patients who appeared to be septic, who often received blood cultures before receiving antibiotics.

Sources

For more information, contact:

- **John Burton, MD**, Residency Program Director, Department of Emergency Medicine, Albany Medical Center, Albany, NY. Phone: (518) 262-4050. E-mail: BurtonJ@mail.amc.edu.
- **Edward Monico, MD, JD**, Department of Surgery, Section of Emergency Medicine, Yale University School of Medicine, New Haven, CT. Phone: (203) 785-4710. E-mail: edward.monico@yale.edu.
- **James R. Miner, MD, FACEP**, Department of Emergency Medicine, Hennepin County Medical Center, South Minneapolis, MN. Phone: (612) 873-7586. E-mail: miner015@umn.edu.
- **Matthew Rice, MD, JD, FACEP**, Northwest Emergency Physicians of TEAMHealth, Federal Way, WA 98003. Phone: (253) 838-6180, ext. 2118. E-mail: Matt_Rice@teamhealth.com.

However, Rice says blood cultures are now being performed in EDs more frequently, due to various recommendations in evaluating and treating patients.

One problem with this, says Rice, is that a significant percentage of blood cultures collected in EDs are interpreted as positive by the laboratory, when in fact the results are contaminants from the blood culture drawing process, such as the skin or equipment not having been cleaned properly.

Additionally, some positive cultures indicating bacteria growing in a patient's blood may not be relevant to a patient's clinical course. The patient, even if infected with the bacteria growing in a culture several days after the culture was obtained, may subsequently be well and may not need further treatment. "Thus, positive blood cultures must be assessed against other clinical information in order to provide the best care for each patient," says Rice.

Rice says that every positive blood culture should be assessed by an experienced clinician to "risk stratify" the culture result with the patient's original clinical information.

"In some cases, this may be enough information that further contact with the patient is not imperative," says Rice. In cases with uncertainty, however, the patient should be contacted to determine the necessity for a timely clinical re-evaluation.

If you don't have a follow-up process that is faithfully followed, you leave yourself open to the possibility that a patient may have a bacterial process going on that requires a specific treatment, warns Rice, that if left unattended will result in that person and possibly others suffering increased morbidity or mortality.

"From a risk perspective, a positive blood culture in a patient who is not appropriately treated because of a failure to appropriately follow up with the patient is often interpreted as negligence on the part of the treating physician an treating institution," says Rice. "It is particularly damaging evidence in risk cases when a known abnormality is not appropriately addressed."

References

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2. Campbell SG, Marrie TJ, Anstey R. Utility of blood cultures in the management of adults with community acquired pneumonia discharged from the emergency department. *Emerg Med J* 2003;20: 521-523.
3. Corbo J, Friedman B, Bijur P, et al. Limited usefulness of initial blood cultures in community acquired pneumonia. *Emerg Med J* 2004;21:446-448.

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 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*

21. Which of the following elements should be included in documentation about a patient who leaves against medical advice (AMA)?
    A, The patient's ability to provide a lucid history, reasoning, and exam findings that contribute to assertions of competence and capacity.
    B. That the patient was informed of the extent and limitation of the evaluation conducted up to the point he or she decided to leave AMA.
    C. What specific care and treatment were refused.
    D. All of the above

22. Which is advisable if an ED physician anticipates that he or she may be sued by a patient?
    A. Contacting the group's insurance carrier only after a suit is filed.
    B. Discussing the potential suit with the hospital's risk manager or legal counsel only after consultation with your insurance carrier or group's attorney.
    C. Informing the patient's attorney if other caregivers are to blame for an adverse result.
    D. Investigating the patient's potential claim by discussing the matter privately with colleagues.

23. Which is recommended for documentation in the event that a lawsuit is filed against an ED physician?
    A. Backdate addendums in the record.
    B. Create an addendum to the patient's chart to explain extenuating circumstances after receiving notice of an intent to sue.
    C. If you create a clarifying addendum, date it when it was actually written.
    D. Prepare personal notes to document items that aren't in the patient's chart.

24. Which is true regarding items discoverable in the event of a lawsuit against an ED physician?
    A. Information given verbally or in writing to the hospital's risk managers is never discoverable.
    B. Personal correspondence with non-involved parties is not discoverable.
    C. Information given to an attorney is protected only after the lawsuit is actually filed.
    D. All notes, conversations, or e-mails with colleagues, whether inside or outside the ED, are typically subject to discovery.

25. Which is recommended when a positive blood culture comes back for a patient discharged from the ED?
    A. A patient with a blood culture that isn't an obvious contaminant should be contacted immediately for follow up.
    B. The ordering physician is not legally responsible for acting on the findings of the results if the test was done in the emergency department.
    C. Avoid documenting who will be responsible for the interpretation of blood culture results in the patient's chart.
    D. Follow-up on every positive culture should be done in the ED, even if the patient's primary care physician has agreed to accept responsibility.

Answers: 21. D, 22. B, 23. C, 24. D, 25. A

ED Legal Letter™
The Essential Monthly Guide to Emergency Medicine Malpractice Prevention and Risk Management
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ELB060109TM

PLEASE NOTE: If your correct name and address do not appear below, please complete the section at right.

Please make label address corrections here or PRINT address information to receive a letter of credit.

Account # _____
Name: _____
Company: _____
Address: _____
City: _____
State: _____
Zip _____
Fax: _____
Phone: _____
E-mail: _____

CNE/CME Evaluation

Please take a moment to answer the following questions to let us know your thoughts on the CNE/CME program. Fill in the appropriate space and return this page in the envelope provided. **You must return this evaluation to receive your letter of credit. ACEP members — Please see reverse side for option to mail in answers.** Thank you.

CORRECT ● **INCORRECT** ⊘ ✓ ✗ ⚠

1. In which program do you participate? ○ CNE ○ CME
2. If you are claiming physician credits, please indicate the appropriate credential: ○ MD ○ DO ○ Other _____
3. If you are claiming nursing contact hours, please indicate your highest credential: ○ RN ○ NP ○ Other _____

After participating in this program, I am able to:	**Strongly Disagree**	**Disagree**	**Slightly Disagree**	**Slightly Agree**	**Agree**	**Strongly Agree**
4. Identify legal issues relating to emergency medicine practice.	○	○	○	○	○	○
5. Explain how these issues affect nurses, physicians, legal counsel, management, and patients.	○	○	○	○	○	○
6. Integrate practical solutions to reduce risk into the ED practitioner's daily practices.	○	○	○	○	○	○
7. The test questions were clear and appropriate.	○	○	○	○	○	○
8. I detected no commercial bias in this activity.	○	○	○	○	○	○
9. This activity reaffirmed my clinical practice.	○	○	○	○	○	○
10. This activity has changed my clinical practice.	○	○	○	○	○	○

If so, how? _____

11. How many minutes do you estimate it took you to complete this entire semester (6 issues) activity? Please include time for reading, reviewing, answering the questions, and comparing your answers with the correct ones listed. _____ minutes.
12. Do you have any general comments about the effectiveness of this CNE/CME program?

_____

I have completed the requirements for this activity.

Name (printed) _____ **Signature** _____

Nursing license number ***(required for nurses licensed by the state of California)*** _____

In accordance with ACEP requirements, below we provide the option for ACEP members to submit their answers for this CME activity. If you wish to submit answers to this activity, please refer to Vol. 20, Nos. 1-6 and circle the correct responses.

JANUARY 2009

Damage Caps and EMTALA

1. A B C D
2. A B C D
3. A B C D
4. A B

FEBRUARY 2009

Imaging Interpretation Discrepancies

5. A B C D
6. A B C D
7. A B
8. A B C D

MARCH 2009

Discussions about Patient Death

9. A B C D
10. A B C D
11. A B C D
12. A B C D

APRIL 2009

Inappropriate Behavior in the ED Workplace

13. A B
14. A B C D
15. A B C D
16. A B C D

MAY 2009

ED Triage

17. A B C D
18. A B C D
19. A B C D
20. A B C D

JUNE 2009

Patient Leaving AMA

21. A B C D
22. A B C D
23. A B C D
24. A B C D
25. A B
26. A B C D