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Recent Rulings May Slow Plundering of State Malpractice Fund Surpluses

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

During past medical malpractice crises, many states established "patient compensation funds" to provide accessible and affordable medical liability insurance to health care providers.[1] Also called Malpractice Premium Assistance Funds or Medical Professional Liability Catastrophe Loss Funds (or CAT funds), they were created to preserve access to medical care by providing access to and / or subsidized malpractice insurance premiums to health care providers unable to secure private liability insurance or having difficulty remaining in practice due to the escalating costs of their premiums.[1,2]

These patient compensation funds are quasi-public organizations created by state legislatures, but their financing comes entirely from premiums paid by physicians, hospitals, and other health care providers. The state itself doesn't provide the financing (New York is an exception) or guarantee solvency of the fund should the premiums collected be insufficient to cover the fund's actual losses. In essence, the funds are a state-sanctioned mechanism for providers to pool risk, similar to the approach of private risk retention groups (RRGs).[1]

In the years following the most recent malpractice crisis early this decade, these funds accumulated significant capital, due in part to early increases in premiums, efficient operations, prudent claims management, tort reform laws, and maintenance of sound reserves.

However, the funds' cash balances are coming under attack by revenue-starved states with large budget deficits from insatiable spending and the recent depression. The political pressure to "reassign" or "plunder" (depending upon one's perspective) the millions of dollars of accumulated surplus in the medical liability funds is simply irresistible.

Wisconsin

Wisconsin's experience is a case in point. Physicians and nurse anesthetists in Wisconsin are required to contribute to the states' Injured Patients and Families Compensation Fund (the "Fund"), which provides insurance coverage for excess medical malpractice claims (above a cap on amounts payable directly by the providers).[3] In 2007, Governor Jim Doyle approved a transfer of $200 million from the Fund to finance various Medicaid-related health care programs, none of which

had anything to do with excess malpractice claims.[4]

The Wisconsin Medical Society sued the state, claiming the monies were protected dollars to be used exclusively to decrease malpractice premiums and compensate injured patients.[5] The physicians also claimed, among other things, that the transfer constituted a taking of private property for public purposes without just compensation, in violation of the federal and state constitutions; and a discriminatory tax, in violation of the equal protection clauses of the federal and state constitutions.[5]

The state argued that the physicians did not have a property interest in the Fund, and that the legislature must have the "necessary latitude to adapt its interventions to pressing public policy challenges in the face of changed circumstances."[5] In other words, the state was asking the court to protect the legislature's ability to respond to pressing public policy concerns, and to change its laws as situations change. This was despite the fact that the statute that created the Fund explicitly stated:

1. "Moneys in the Fund may not be used for any other purpose of the state"; and that
2. "The Fund is held in irrevocable trust for the sole benefit of the healthcare providers participating in the Funds and proper claimants."[3]

The trial court agreed with the state that the Wisconsin physicians did not have a property interest in the state's patient compensation fund, and concluded they had no right to excess money in the Fund because they already received the benefit of the insurance coverage they purchased through the pool.[5]

The case is now on appeal, and the American Medical Association (AMA) and various state medical societies have filed friend-of-the-court briefs supporting the Wisconsin physicians, arguing that the fund was meant to keep insurance rates affordable and protect injured patients, not provide funding for the state's Medicaid programs. The AMA is particularly miffed by the transfer because it acts as a selective tax on physicians for general revenue use.[6]

The $200 million removed from the Fund constituted approximately 25% of the Fund's net assets, and now the fund is in some difficulty, resulting in an assessment against the physicians of a 25% fee increase over five years, with a jump of 10% already in 2009. In its complaint, the medical society had alleged the withdrawal would put the Fund in a serious deficit accounting position, hurt its investment earnings, result in insufficient funds to cover claims that have occurred but have not yet been paid, and force increased assessments on the physicians to bring the fund back into balance.[7]

The trustees of the Fund are left to wonder: Why rebuild the reserves or surplus, if in the future the state can just appropriate the money for its own use?

Pennsylvania

The Pennsylvania Medical Society and the Hospital Associations of the state are in a real dogfight with the legislature and administration of Gov. Ed Rendell regarding the state-run medical liability coverage funds.

Since the mid-1970s, Pennsylvania has assessed physicians and other health care providers annual fees to finance its MCARE Fund (Medical Care Availability and Reduction of Error Fund).[8] Physicians must carry $1 million in liability coverage. The first $500,000 must be obtained from private insurers (or the state's Joint Underwriting Association, the liability insurer of last resort for physicians who can't obtain coverage elsewhere). The MCARE fund provides the second $500,000 of coverage.[8]

However, unlike a traditional insurer, MCARE is a pay-as-you-go plan; it sets aside absolutely no reserves to pay future claims. It simply charges physicians, hos-

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

pitals, and other health care providers an annual assessment to pay current claims and operating expenses. In 2008, the fund paid out claims totaling $174 million on claims that exceeded the $500,000 primary level of coverage.[9] In 2009, the assessment was 19% of the primary premium paid by the providers, and the 2010 assessment, which was announced a couple of weeks ago, will be 21% of the primary premium amount.[10]

The Pennsylvania Medical Society and the hospitals sued the state because the state allowed the MCARE surplus to accumulate in the Fund instead of using the money to reduce the annual assessments, causing the assessments to increase each year.[11]

Back in 2003, at the height of the most recent malpractice crisis in Pennsylvania, the state created a second fund called the Healthcare Provider Retention Account. It was financed by cigarette taxes with the intent to keep doctors practicing in the state by subsidizing the fees they had to pay into the MCARE Fund. In 2007, the medical society and the hospitals learned that state officials had stopped transferring the money into the MCARE Fund in 2005, a total amount of around $615 million.[11]

When the state asserted that it was not required to make the transfer into the MCARE Fund, the Medical Society and the hospital sued the state again, and a few months ago the Pennsylvania trial court denied the state's 2009 motion to dismiss the lawsuit, allowing the suit to proceed to trial, though a trial date hasn't been set yet.[11,12]

The case made national news because of the stalemate between the legislature and Gov. Rendell over his proposal to use the money to cover the uninsured, while the lawmakers wanted to tap the funds to cover other budget shortfalls.

Now the legislature intends to transfer money out of the MCARE Fund itself into the state's general fund to help shore up a $3.2 billion budget deficit, to the tune of $100 million — roughly two-thirds of the entire balance in the MCARE Fund. The physicians and hospitals see this as an unfair and illegal raid on money they paid to provide malpractice insurance coverage, and may now have to file a third lawsuit against the state, for what is effectively placing a special tax on physicians to cover the state's budget shortfall.[11]

Worse yet, is the possibility that the state insurance commissioner may begin phasing out MCARE entirely, since the availability of med-mal insurance is no longer an acute issue in the state. If that happens, the Fund will be left with outstanding claims that still need to be settled or litigated, but no reserves to actually pay the claims since it is a pay-as-you-go system. The estimated outstanding liability is $1.7 billion, and there currently is no set plan to pay off the unfunded liability.[11] The annual assessments for MCARE could continue long after physicians no longer obtain coverage from the Fund, and even physicians, such as those just coming out of residencies, who never obtained coverage via the Fund would be stuck paying the assessments ad infinitum. Why would any new residency graduate start practice in Pennsylvania?[13]

New Hampshire

Health care providers have had better luck in the Granite state. In the recent case of *Tuttle v. New Hampshire Medical Malpractice Joint Underwriting Association*, the court ruled that surplus funds in a medical malpractice fund belonged to the policyholders, and therefore the state of New Hampshire did not have the right to direct those funds to other state purposes.[14]

New Hampshire has a Medical Malpractice Joint Underwriting Association (JUA), and all insurers authorized to write medical liability insurance in the state are required to participate in the JUA, paying an assessment based on their portion of the net direct premiums written in the state.[15] The JUA issues individual policies to its policyholders, which are both "assessable" and "participating." Assessable means that the JUA can assess the policyholder to cover any deficits in the Fund; and participating means the insured participates in the earnings and surplus of the Fund.

The Fund gradually accumulated a surplus estimated at somewhere between $145 million and $160 million.[16] The legislature, again because of budget deficits, in June of 2009 enacted a statute requiring the JUA to transfer $110 million of its surplus into the state's general fund.[17]

The policyholders — mostly physicians, but also nurses, physician assistants, nursing homes, and hospitals — first sued to disqualify the state attorney general from simultaneous representing the governor/Department of Insurance and the JUA, which would have been akin to the proverbial fox guarding the chicken coop. The court had no trouble determining that a conflict of interest existed under the state Rules of Professional Conduct,[18] and granted the policyholders motion to bar the attorney general from representing the JUA.[19] The court also determined that the JUA was a separate entity from the state insurance department and not a part of the executive branch, and therefore was entitled to its own counsel. Interestingly, the attorney general had never represented the JUA previously, in any of its prior litigations.[14]

Next the JUA won the case on the merits at the trial court level, though the state has appealed the issues to the state supreme court.[14]

The state argued in favor of the statute, claiming that

the JUA was a state agency — and therefore the funds belong to the state — and that the policyholders have no vested property right in the excess surplus.[14] However, the court determined that the JUA was a quasi public/private entity, not a state agency, and that the statute was unconstitutional by violating the Takings Clause of the United States Constitution, and a similar clause in the New Hampshire Constitution.[20,21] These clauses guarantee that the government shall not take private property "for public use without just compensation."

The Court found that the surplus funds were indeed owned by the policyholders of the JUA, and that the "specific property interest the policyholders claim in this case is a contractual and statutory/regulatory right to the beneficial interest in surplus JUA funds."[14] It came to this conclusion by looking at both the organization of the JUA, and the manner by which it was funded. The JUA board has broad powers and authority that does not require government oversight — a strong argument in favor of its sovereignty from the state government. In addition, the State neither provided start-up capital nor contributed financially in any way to the JUA.[14] Any losses or expenses in excess of the premiums paid to the JUA are covered by insured members, and per statute any surplus shall be distributed by the JUA's board to the health care providers (or saved to "reduce future assessments of the association").[14] Other factors considered by the court included: employees and board members were not state employees; the JUA does not have sovereign immunity and can be sued; and the JUA has its own legal counsel and has not been represented by the attorney general.[14]

Moreover, the court continued, "taking JUA funds would decrease investment earnings which are important to the JUA's ability to meet operating costs and malpractice claims"; and "Not only is the likelihood that the policyholders will receive a dividend decreased, but the likelihood that members and policyholders may be assessed to cover future liability is increased."[14]

The court also found that the statute interfered with the policyholders' freedom to contract. The policyholders' agreements with the JUA are governed by contract, and the Court found that these contracts are clear as to the rights of the policyholders to dividends if indeed a surplus is found to exist.[14]

The legislature had reasoned that "the purpose of promoting access to needed health care would be better served through a transfer of the excess surplus…to the general fund."[14] Again, a state legislature wanted the latitude to change course to address "pressing public policy challenges in the face of changed circumstances." But the court said the state's rationale that the transfer served an important public interest in promoting access to care did not justify the government's action. The judge noted it was up to the JUA to determine if a surplus existed, which it had not done.[14]

Conclusion

In light of the economic depression and dismal status of state budget deficits, the states may continue attempts to siphon off medical malpractice fund surpluses into their general funds. Continued diligence and persistent litigation is necessary to ensure that creative legislatures do not find loopholes or other mechanisms in which to seize these funds, which would only jeopardize access to physician services in those states.

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EDs Get Added Protection against Malpractice Suits

Will defensive medicine be a thing of the past?

In a growing number of states, including Florida, Georgia, Texas and South Carolina, Utah, Arizona, Michigan, Minnesota, and North Carolina, legislation is being introduced to give emergency department (ED) physicians added protections against malpractice lawsuits.

Is this good news for EDs? "Absolutely," says **Wayne Guerra, MD, MBA**, vice president of Serio Physician Management, a Littleton, CO-based company that provides management services to hospital-based physicians and hospitals.

"Emergency physicians do not have an established relationship with many of their patients, and as a result are at risk for increased malpractice suits," says Guerra. "Studies have shown that the fear of malpractice litigation increases the use of diagnostic testing and admission of low-risk patients with chest pain.[1] Protecting emergency physicians from frivolous lawsuits will help reduce this fear and increase the use of evidence-based medicine."

Guerra says that emergency medicine physicians should not be shielded from mistakes, but do need to be protected from lawsuits generated from a bad outcome where the care was appropriate.

Fewer Unnecessary Tests

Would having increased malpractice protection enable emergency physicians to stop practicing defensive medicine and instead, work up patients according to the clinical situation and evidence-based medicine? Possibly so. "Currently, the decision on whether a medical mistake is made is left up to a jury, who many times does not understand the complexities of the case," says Guerra. "This causes many physicians to order unnecessary tests to rule out very unlikely diseases."

Guerra says that increased malpractice protection would increase the quality of care, because it would encourage compliance with best practices. "Safe harbor from medical malpractice would increase the use of best practice standards, if the doctors knew they could not be sued if they followed the standard," says Guerra.

Guerra notes that of all computed tomography (CT) scans done, which number 20 million a year in adults and 1 million in children, a third do not meet medical need criteria. "These scans are not without risk, and are believed to result in 1.5% to 2% of all cancers in the United States," he says.[2] "Once ED physicians trust the new protection laws, they would be more willing to forgo potentially harmful unnecessary imaging studies."

There is no doubt that fear of lawsuits drives the decisions made by emergency physicians to some degree, says **Andrew Garlisi, MD, MPH, MBA, VAQSF**, medical director for Geauga County EMS and co-director of University Hospitals Geauga Medical Center's Chest Pain Center in Chardon, OH. "It takes only one bad experience with the medical legal system, whether justified or not, to make an indelible mark on the practice habits of physicians," he says. "But this is not necessarily a negative situation."

How fear of lawsuits translates to daily practice depends on numerous factors, says Garlisi. These include the particular physician's tolerance for risk, the type of ED, support provided by hospital administration, presence or absence of consulting physicians, whether a follow-up physician is willing to see the patient, and the chief complaint.

More Access to Specialists

Ohio's legislation would give qualified civil immunity to ED physicians, who could be sued only if "willful or wanton" misconduct occurred. According to **William J. Naber, MD, FACEP**, an assistant professor in the Department of Emergency Medicine at the University of Cincinnati's College of Medicine, this could have a positive impact on crowding, patient boarding and lack of on-call specialists.

Naber notes that ED physicians provide high-quality care without regard to the patient's insurance status or ability to pay, and need on-call specialists to do so. "Frequently, the on-call specialists will stop taking call from emergency departments," says Naber. "I can't say that I blame them. They are assuming increased liability and decreased or no reimbursement

—continued on page 8

SPECIAL REPORT

Case Studies in EMS Medical Control

By **Bernard Heilicser, DO, MS, FACEP, FACOEP,** Medical Director, South Cook County EMS System; Director, Medical Ethics Program, Ingalls Hospital, Harvey, IL.

A 50-year-old female called emergency medical services (EMS) because she is short of breath. She has a recent history of pneumonia and received outpatient treatment. The paramedics arrive and find the patient in moderate respiratory distress. The patient states she wants to be transported to Our Lady of the Financially Secure Hospital (Hospital A) because this is where her health maintenance organization (HMO) is; the estimated time of arrival (ETA) would be 15 minutes. Medical control directs them to go to the closest facility, Destitute Medical Center (Hospital B), with an ETA of 3 minutes. The patient adamantly refuses and states she will refuse treatment rather than be transported to the directed hospital. What would be the appropriate action by EMS?

The Importance of Medical Control in EMS

Medical control is a function in emergency medicine that is often underappreciated and relegated to a "radio nurse." Different systems have different approaches to the direction of an EMS provider, whether it be simple subjective oversight of an EMS call, or specific point-by-point direction. The assigned individual who takes the radio call may be an emergency department (ED) tech, a nurse or a physician. Regardless, who has the ultimate on-line responsibility for that call? The ED physician does, whether in the radio room or not.

Consequently, decisions affecting patient care by EMS can have very significant medical legal impact on the on duty ED physician. (The off-duty medical director has 24/7 responsibility, but cannot control every call).

Patient Refusing Direction from Medical Control

So, we have a patient in moderate respiratory distress who will not abide by medical control. What should EMS do, and what should medical control do to help resolve this situation?

The patient has stated she will not go to Hospital B. Can she refuse? This would first bring into play her decision-making capacity. In general, patients who demonstrate decision-making capacity can refuse medical care. Although decision-making capacity is more a medical determination than a legal decision, legal principles would ask if the patient understands their condition / situation, and do they appreciate the choices?

Informed consent / refusal typically involves the patient being aware of the consequences of their actions and having been given the risks and benefits. These situations are state-law-specific. We tend to disregard patients' autonomous requests when they are not in agreement with what we perceive to be in their best interest. Physicians do this at their own jeopardy, because patients have the legal right to accept or reject treatment.[1] Rumor has it that we also divert ambulances to help decompress a crowded ED. This patient is in moderate respiratory distress, but she was capable of discriminating the potential financial ramifications of hospital destination. EMS calls back to medical control and reiterates their concern. Medical control states the patient cannot go to Hospital A, and should then sign a refusal on the EMS run sheet and be allowed to fend for herself. True, the patient has demonstrated decision-making capacity and was given the opportunity for informed refusal, thereby giving protection to the EMS providers and the hospital.[2] However, is this in her best interest?

What have we accomplished? The patient will now call a taxi, go by private car, or just stay home. Is it preferable that this patient present to Hospital A by these means or by ambulance? Cardiopulmonary resuscitation (CPR) in a taxi would not bode well. If Hospital A was on bypass / diversion, would this change the approach? With a formal policy addressing diversion, protection may be afforded.[3]

Medical control needs to be flexible and handle each EMS call on a case-by-case basis. Ultimately, the question is, "What would be in the patient's best interest in the context of potential harm?" Likely, CPR in an ambulance rather than in a taxi.

Should a Spouse Dictate Transport?

A 78-year-old male is profoundly short of breath. He has a history of congestive heart failure. His oxygen saturation is 80% on room air. EMS calls medical control because there is disagreement about which hospital to transport. The closest, Hospital A, is five minutes away, while Hospital B has an ETA of 15 minutes. The patient is markedly confused. His wife demands he go to Hospital B, because that is where their physician is on staff, and he said he would meet them. EMS is concerned about the prolonged transport time. What should medical control do?

The patient is in respiratory distress and obviously lacks decision-making capacity. He can't refuse transport to the closest facility. Does his wife have standing to demand further transport?

Although spouses may think they are each other's legal guardian, they are not. A legal guardian is appointed by a judge when an individual is deemed incompetent. This individual can be a spouse, but marriage does not confer this authority. In this case, if the wife was the patient's legal guardian, then she might influence the decision. A power of attorney for health care is empowered to make all medical decisions for the patient when the patient cannot. That status was not present in this case. The various states have health care surrogate acts, but this emergency situation would not allow for clarification of its applicability.

The patient is in critical condition, so although EMS would like to accommodate the wife, her demand should not be honored. Essentially, one person cannot condemn another to death. The patient lacks decision-making capacity and his spouse is interfering with the ability to provide the appropriate medical care.[4,5] In this situation, we must assume what a reasonable person would want in the absence of an advance directive, and treat the patient accordingly. This patient should be sent to the closest hospital.

Advance Directives: Fact or Fiction?

EMS is dispatched to a local nursing home for a patient in cardiac arrest. On arrival they find an 80-year-old male on the floor in the dining area, with CPR in progress. They take over the resuscitation and commence advanced life support. The monitor shows asystole. Moments later, a nurse runs up to the crew and states, "He is a 'do not resuscitate' (DNR)." The patient has a long list of chronic medical problems, including Alzheimer's disease, but no specific terminal illness. The documentation of the DNR is actually valid. (This does not happen frequently, as often an inappropriate surrogate has made the request or a demented patient has signed the form.) The paramedics initiate contact with medical control, with the hope of terminating the resuscitative effort. Would you comply?

Cardiopulmonary resuscitation is one of the few things we do to someone without their consent. It takes a formal advance directive to deter this medical modality. Anyone can have a DNR order at any time. These declarations are encouraged, and when not present in certain circumstances, are frowned upon by medical providers. Although not terminal, our patient had a valid DNR order in place. Medical control could easily order the paramedics to discontinue their effort.

As a volunteer firefighter, I responded to this call and took formal responsibility just as medical control was being contacted. A quick assessment of the situation revealed an interesting observation. Directly next to the patient was a feeding chair. On the tray of the chair were diced-up hot dogs. As the crew was contacting medical control, one of paramedics had initiated an attempt at intubation. I reached for a McGill forceps; the paramedic visualized a foreign body — a hot dog. A quick grab with the McGill, some Ambu bag ventilations, and the patient regained a pulse and spontaneous respirations. He was discharged from the hospital three days later, perhaps minimally more confused than before his dinner four days prior.

Were we wrong to resuscitate this gentleman? True, he did have a DNR. However, his precipitating cardiac event was a foreign body that caused an airway obstruction, and was easily removed. Was the intent of the DNR, as most are, to prevent aggressive resuscitations and consequent admission to a critical care unit with tubes in every orifice? Does an acute episodic intercurrent event preclude the intent of a DNR? One can certainly question the appropriateness of the intervention and subsequent outcome of this case. However, would an apparent simple radio call to medical control truly have portrayed an environment that met the intent of the DNR?

Summary

The three cases presented in this discussion are all real. They demonstrate some of the difficult decisions that are placed on medical control for EMS. When does a patient's autonomous right trump our desire to be beneficent (that is, what we believe to be in the patient's best interest)? Who is empowered to make medical decisions for a patient incapable of such decisions? And, does a DNR always mean what we perceive it to be?

Medical control is much more than simple rote decisions; there will always be situations that challenge us to think, be creative, and improvise. Not unlike in the practice of emergency medicine, the liabilities are apparent, but the rewards greater.

The author expresses gratitude to attorneys Diane Jacoby and Jason Danielian for expertise and advice, and to Dawn McDermott for administrative support.

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continued from page 5

for the services they provide to emergency department patients. Why would any physician choose to practice in this environment?"

Naber says legislation like the Ohio bill, which states its purpose is "to provide appropriately limited liability for these emergency medical providers," will result in more on-call specialists, better access to specialty care, and improved overall quality of emergency care, because clinicians providing on-call care to emergency patients would be included in the protection.

"This is great news for emergency medicine. Emergency physicians provide care at all hours of the day and night to some of the sickest patients, often with little or no medical history. Ironically, the sicker patients are, the more you need that critical medical information, but are less likely able to obtain it."

Naber says that the limitation on liability is "clearly appropriate when providing EMTALA-mandated care in this difficult environment."

"People who feel that limited liability will decrease the incentive for quality improvement obviously don't practice medicine in this environment. They don't understand that lawsuit fear doesn't drive or determine the quality of care," says Naber. "Lawsuit fear clearly correlates, however, with increased cost of care."

End to frivolous suits?

The definition of "willful or wanton misconduct" can and will be argued, says Garlisi. He gives the example of an emergency physician who evaluates a 43-year-old male with chest pain. The patient has "non-specific" EKG changes, and chest wall tenderness. The physician concludes that the chest pain is musculoskeletal and discharges the patient home. The patient dies nine hours later from myocardial infarction.

Would this error in diagnosis and disposition be considered "wanton and willful," or did the physician truly believe the chest pain was benign and make a decision based upon careful consideration of events, physical findings and ancillary results? "Of course, this would be the subject of some debate," says Garlisi. The same question could be asked, he says, if an emergency physician does not diagnose a deadly dissecting aortic aneurysm, or pulmonary embolism if the signs and symptoms are suggestive, but not glaringly obvious.

However, Garlisi says that it is likely that emergency physicians would be excused from misdiagnosis, even with serious negative outcomes, as long as he or she followed some reasonable course of action and the intent was genuine and in the best interest of the patient.

"For the emergency physician who has suffered through months of depositions and discussions with malpractice defense attorneys regarding trivial or frivolous matters, as in my case recently when I was accused of kidnapping, assault and battery because I ordered a medical evaluation on an elderly patient with chronic dementia and acute agitation, this is great news indeed," says Garlisi.

After one year, the case was finally dismissed. "While the right decision was made, and the case dropped, very few people would realize the extent to which such a case adds unnecessary stress, and emotional turmoil and monumental time waste for the physician involved," says Garlisi.

Companies which hire and pay emergency physicians are likely to benefit. "Over the past two decades, large emergency staffing companies have all but taken over the business of emergency medicine," Garlisi says. "Malpractice insurance premiums are major expenses, and reduction of lawsuits could help keep insurance costs from increasing."

Bad impact on quality?

While Naber asserts that fear of lawsuits does not drive or determine quality of care, Garlisi is of the opinion that there might be cause for some concern that limited liability might have a negative impact on quality and patient safety.

"Even in healthy economic circumstances, hospitals operate on thin margins," he says. "Administrators are forced to focus their resources on the vital departments and services which generate the bulk of revenue."

Unfortunately, EDs are not a high priority for many hospitals. "For many years, emergency physicians have raised concerns about dysfunctional processes, antiquated work environments, substandard staffing, inability to move patients from the ED up to the inpatient units, inconsistent services from lab and radiology, and an inability to 'ramp up' performance to meet

Sources

For more information, contact:

- **Andrew Garlisi, MD, MPH, MBA, VAQSF**, University Hospitals Geauga Medical Center, Chardon, OH. Phone: (330) 656-9304. E-mail: garlisi@adelphia.net.
- **Wayne Guerra, MD, MBA**, Vice President, Serio Physician Management LLC, Littleton, CO. Phone: (303) 759-0854. E-mail: wayneguerra@comcast.net.
- **William J. Naber, MD, FACEP**, Assistant Professor, Department of Emergency Medicine, University of Cincinnati. Phone: (513) 600-4749. E-mail: naberwj@uc.edu.

demands during extremely busy shifts," says Garlisi. "Yet, for all too many emergency departments, not much has changed."

Garlisi raises these questions: With less threat of lawsuits, will administrators reduce ED staffing to cut costs? Will ancillary service availability be reduced or eliminated after midnight? Will other cost-cutting measures be implemented which could affect patient safety? What incentives will there be for hospitals to reduce ED overcrowding or not have patients sit in the waiting area for eight hours to be seen by a physician?

"Staffing patterns no doubt will be affected," says Garlisi. "Administrators could look at patient volume — 'He has only seen 34 patients in his shift' — and scoff at the idea that the emergency physician needs additional staffing to handle the load of complex, seriously ill patients. The administrators do not take into account that those 34 patients generated 14 hospital admissions and / or transfers."

The bottom line, says Garlisi, is that "the emergency physician 'worker bee' in the trenches, whose professional livelihood hangs in the balance, has little or no power to affect policy change which would improve patient safety and reduce medical legal risk to the physician."

As for how the new protections will impact individual ED physicians, Garlisi says that those who are engaged, thorough, and conscientious (and therefore do not generally work in fear of being sued) will probably continue to practice emergency medicine in the same manner. However, "physicians who are 'minimizers' with regard to patient evaluations and those who look for shortcuts in patient care may feel justified in their approach," he says.

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Does a Patient Callback System Prevent ED Suits?

Experts say that an ED patient callback system can dramatically reduce liability risks, but very few EDs have this in place.

Tom Scaletta, MD, medical director of a high-volume community hospital in a Chicago suburb, says that his interest in calling back emergency medicine patients began a decade ago when he created and implemented programs in two high-volume EDs that he directed. "I staffed the position with dedicated clerks who attempted to reach every discharged patient," he says.

Scaletta is president of Emergency Excellence (EmEx), a Chicago-based organization that improves patient care and efficiency in the ED, which recently introduced Em-Ex Contact, a solution for performing patient callbacks and phone-based patient satisfaction surveys. A trained call center team contacts ED patients soon after discharge to ask about the patient's condition, whether they understood their discharge instructions, and whether they have had any problems obtaining follow-up care.

Several years ago, Edward Hospital's callback program, implemented by Scaletta, was acknowledged by the Robert Wood Johnson Foundation as a best practice.

"Still, very few hospitals currently have such programs," says Scaletta. "In my experience, which spans several hundred thousand patient follow-up contacts, there was never a claim related to the act of calling back patients. Moreover, literally dozens of lawsuits were averted or substantially muted by having the immediately retrievable callback data."

Scaletta says that typical EDs have claims formally filed at a rate of roughly one or two in every 10,000 discharged patients. "Imagine if the patient's condition was stable or improving, understood his or her discharge instructions and had no barriers to follow-up care, and you documented this. Or the patient's condition had worsened, there were aftercare questions, or a follow-up appointment could not be arranged, and you did something about it," says Scaletta.

In addition, Scaletta says he has found that patients appreciate telephone well-being checks. "As a result, patient satisfaction scores increase. The goodwill this action creates minimizes the chance that a patient will take an untoward outcome out on a hospital or physician by filing a claim. Further, staff becomes nicer and more attentive to patients when they know there will be a follow-up call the next day."

If physicians and nurses are mandated to perform callbacks amidst patient care duties, they are often resentful because it distracts them from focusing on active cases. "Also, they almost never report complaints about colleagues," says Scaletta. "And, having scores of physicians and nurses doing callbacks means there will be inconsistent methods and documentation."

Scaletta adds that a dedicated callback clerk is more likely to be trained with regard to patient privacy regulations for leaving voicemail messages and conversing with family members or roommates. "They are uniformly scripted in how to properly refer worsening patients back to a provider," he says. "Callbacks are particularly important in the elderly, since a higher rate

get worse and need to return to the ER or fail to make follow-up appointments."

Take these steps

Patient callback systems are "a valuable communication and documentation tool in a busy ED," according to **Victoria L. Vance, JD**, a health care attorney with Tucker Ellis & West LLP in Cleveland. Vance is former senior counsel and director of litigation for The Cleveland Clinic Foundation.

Vance refers to a recent study which looked at the potential for problems during handoffs from ED to primary care physicians. Researchers found that many patients failed to follow up in clinic as instructed, perhaps because they did not fully comprehend discharge instructions.[1]

With this in mind, Vance says that callbacks provide an opportunity to reconfirm the patient's status, reassure that the patient's post-discharge course is proceeding as expected, clarify instructions, answer questions, and convey final lab or radiology results.

"This is particularly valuable for vulnerable and 'at risk' patient populations such as pediatrics and the elderly, where clarity and reinforcement is valuable," says Vance. "With these groups, the risk of a delay in recognition of symptoms may be high, and the margin for error is small." If implementing a patient callback system, Vance says that the following are important risk management considerations:

Thoughtful patient selection. Will the callback program apply to all ED patients, or just select populations, such as all pediatric patients under age 10, all patients older than age 65, patients who were discharged with final diagnostic results pending, or patients seen on weekends?

"Applying the program to all patients offers greater coverage and benefits, but also will mandate strict compliance that the goal of 100% callbacks must be met," says Vance. "If applying the program to select population groups, such groups must have a rational basis and not appear discriminatory. You can't select patients by gender, socioeconomic basis, or insurance status."

Strict compliance with program criteria. Calls need to occur within the designated follow-up window, such as 24 or 48 hours. "Failure to call or delays in calling may be used as evidence in the event of a poor outcome," says Vance. "As with any policy, the failure to follow a policy may be viewed as evidence of breach of the standard of care in many jurisdictions."

Training of personnel. The individuals who make the follow-up calls must be informed about the nature and circumstances of the patient's ED visit, to engage in a meaningful interaction with the patient. The caller should have access to the medical record and the discharge instructions, be able to respond to the patient's questions, and have strict instructions for when to refer the call to a physician.

"Alternatively, a dedicated callback clerk must be able to immediately refer a patient needing medical advice to a nurse who can access the ED record," says Scaletta.

Documentation. "The time, date, and content of the call must be documented," says Vance. "Work off of a simple checklist with key questions or topics, such as the patient's status, whether prescriptions have been filled, and does the patient have any questions?"

Patient privacy regulations. "Consider giving notice to the patients in the ED that follow up calls will be made," says Vance. "Ask patients at intake if they can designate a friend or family member to share information and results. Get working phone numbers. Then, when calling, the preference should be to speak with the patient directly, but if patient is not available, go to the designated contact person."

Be prepared to take action. "Depending on the content of the call, it may be necessary to provide immediate emergency instructions or even dispatch 911 to the scene," says Vance. "Be prepared."

First, determine goals

Steven J. Davidson, MD, MBA, FACEP, FACPE, chairman of the Department of Emergency Medicine at Maimonides Medical Center in Brooklyn, NY, says that his ED calls back patients when imaging or laboratory final results are either unexpected or different from the conclusion reached at the time the patient was in the ED, and the treatment would be different as a result of this.

"We do not use one of the commercial vendors to call and check on the patient's general well-being, nor

Sources

For more information, contact:

- **Steven J. Davidson, MD, MBA, FACEP, FACPE**, Chairman, Department of Emergency Medicine, Maimonides Medical Center, Brooklyn, NY. Phone: (718) 283-6030. E-mail: SDavidson@maimonidesmed.org.
- **Tom Scaletta, MD, FAAEM**, President, Emergency Excellence, Chicago. Phone: (877) 700-3639. E-mail: tom@emergencyexcellence.com. Web: www.emergencyexcellence.com.
- **Victoria L. Vance, JD**, Tucker Ellis & West LLP, Cleveland, OH. Phone: (216) 696.3360. E-mail: victoria.vance@tuckerellis.com.

do we do that ourselves," says Davidson. "Some of our staff do personally arrange follow-up calls when the clinical determination was uncertain and recognizing a change in the patient's condition early would be advantageous. That's done more often for pediatric patients."

As for liability risks being reduced when callback systems are implemented, Davidson says this "makes sense, because we know that patient and family disgruntlement with the experience and outcome of care is at least as important, if not more important, than the clinical quality of care rendered. A follow-up telephone call, in which the patient is counseled and possibly consoled, may thus be a useful effort towards managing liability risks."

However, Davidson cautions that as with any hospital policy, if your ED has a callback policy and doesn't adhere to it, there is a heightened risk of being found liable if an action is brought against the hospital.

"The real risk is in creating and publishing a policy that calls upon staff to perform in a fashion that they can't reliably deliver," says Davidson. "One is better off doing less. In other words, commit to following up some subset of x-rays; don't commit to calling every patient."

When implementing a callback system, an ED must decide what it's trying to accomplish. "If, as is appropriate for most, one is only implementing patient callback to inform the patient of unanticipated findings and 'wrong' findings, and offering a next step of care, then keep that focus," says Davidson. "In other words, keep it simple."

However, it may be that an ED intends to do more than that with its callback system, such as improving public perception of the hospital or reducing liability.

"Whatever the ED implements, it must implement and maintain with consistency. In my mind, that's the key," says Davidson. "Ultimately, some calls may require an experienced clinician on the telephone."

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CNE/CME *Questions*

1. Which of the following statements is true regarding ED patient callback systems, according to Tom Scaletta, MD, president of Emergency Excellence?
   A. Patient satisfaction scores declined significantly after callback systems were implemented.
   B. Hospitals reported a significant number of claims related to the act of calling back patients.
   C. A dedicated callback clerk is less likely to be trained with regard to patient privacy regulations for leaving voicemail messages and conversing with family members or roommates.
   D. Callbacks are particularly important for elderly patients.

2. Which of the following is recommended for an ED implementing a patient callback system, according to Victoria L. Vance, JD, a health care attorney with Tucker Ellis & West LLP?
   A. It is acceptable to apply callback programs to select population groups based on gender or socioeconomic status.
   B. Calls need to occur within the ED's designated follow up window.
   C. Callers do not need to have access to the medical record and the discharge instructions.
   D. EDs should avoid asking patients at intake in the ED if they can designate a friend or family member to share information and results.

3. "Patient compensation funds" that provide accessible and affordable medical liability insurance to health care providers unable to secure private lia-

bility insurance are NOT funded by the states they serve, EXCEPT in:
A. Wisconsin
B. Pennsylvania
C. New Jersey
D. New York

4. Which of the following individuals may not be empowered to make medical decisions for a patient who lacks decision-making capacity?
A. The legal guardian
B. The patient's attorney
C. The power of attorney for health care
D. The appropriate health care surrogate under state law

5. A patient's spouse is automatically empowered to make all medical decisions for the patient.
A. True
B. False

Answers: 1. D; 2. B; 3. D; 4. B;5. B

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 Objectives

After completing this activity, participants will be able to:
1. Identify legal issues related to emergency medicine practice;
2. Explain how the legal issues related to emergency medicine practice affect nurses, physicians, legal counsel, management and patients; and
3. Integrate practical solutions to reduce risk into daily practice. ■

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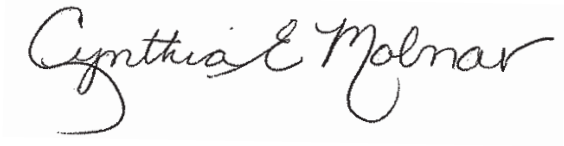

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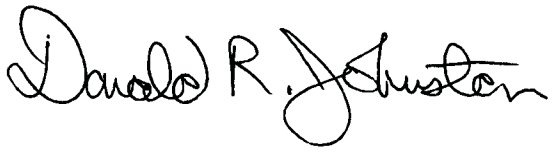

Donald R. Johnston
Senior Vice President/Group Publisher
AHC Media LLC

N #4005

3525 Piedmont Road NE
Building Six, Suite 400
Atlanta, Georgia 30305-1515
Tel (404) 262-7436
Fax (404) 262-7837
www.ahcmedia.com