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Any of Your Online Postings Could Be 'Exhibit A' in Malpractice Trial

Social Media Can Be 'Very, Very Damaging'

A lawsuit involving a terrible outcome, but good emergency department (ED) care, seemed "very defensible" to **Matthew Rice**, MD, JD, FACEP, former senior vice president and chief medical officer at Northwest Emergency Physicians of TEAMHealth in Federal Way, WA. Rice was about to recommend that the hospital vigorously defend the case, but it never got to that point.

During the discovery process, hospital administrators learned of the emergency physician (EP)'s support for legalization of marijuana, as well as his prior use of the drug, says Rice, because his online postings on the matter were unearthed by the plaintiff's attorney.

"The decision was made at the senior level to settle the case. They were worried about the risk of the information being made public in the process of disclosure," says Rice. "That, in my mind, is a very expensive example of how social networking had a negative impact on a case that I believe was very defensible."

Risks Are Many

The liability risks of social media use by EPs and nurses are "many," according to **Michael Blaivas**, MD, RDMS, professor of emergency medicine in the Department of Emergency Medicine at Northside Hospital Forsyth in Cumming, GA.

"Things that could be harmful in patient, personal, or contractual relationships have now become not just hearsay or something that is accidentally overheard, but are documented in writing for anyone to view, review, and keep a record of," says Blaivas.

Rice says an EP's liability risks involving social media can be significant, "if those activities and information provided are not carefully measured against the professional, legal, and social expectations for physicians."

Rice adds that he is aware of several EPs whose careers were impacted negatively because of personal postings. To minimize the chance of problems, Rice says EPs should avoid any postings that they would not want colleagues, patients, opposing attorneys, employers, or loved ones to know about.

Corey M. Slovis, MD, professor and chairman of the Department of Emergency Medicine at Vanderbilt University Medical Center in Nashville, says that if EPs post information on public sites they should "be prepared for the consequences, particularly in this age when people can literally see you in almost any situation if you're not careful."

"Occasionally, suboptimal outcomes occur and a lawsuit might ensue," says Slovis. "Any photos or comments made by any of the health care providers in the room could be used in that lawsuit."

Worse, says Slovis, an EP and the hospital could be sued for a breach of privacy, emotional distress, and punitive damages for blatant disregard of the patient's privacy. Another possibility, he says, is that an EP could post inaccurate information on a patient, resulting in a suit for slander and defamation.

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"The reality is that once you release something on a social network, it becomes a public document," says Rice. "There are very few protections that are associated with this, unless there is some violation of the law or an issue of national security."

Regardless, says Rice, "once it's out there, as they say, 'the horse is out of the barn.'" Rice notes that patient privacy regulations were enacted because some health providers weren't protecting patient information as vigorously as they should have. "Some 15 years ago when they were working on the issue, before it became law, it became clear that patient medical records needed to be protected," he says.

Likewise, EPs have a professional responsibility to protect a patient's private information, whether it's on paper or electronic, says Rice.

Rice notes that even very confidential information, such as national secrets, turn up on the Web, and once they do, "they are known to the world and you can't stop them or retract them. Even if they are not appropriate or even illegal to show, once they are out, the damage is done," he says.

The question for EPs to answer, says Rice, is "Are you willing to stand by your position or advocacy that you espouse, whatever the cost? That is a price that you should be aware could occur."

Competence Questioned

"Our lives become very open when we discuss things publicly, whether it relates to medicine or anything else that we do," says Rice. "Lawyers can access that information."

Plaintiff's attorneys can use personal postings by EPs to raise real questions about ethics of staff, competence, drug abuse, or alcohol abuse, says Blaivas.

"From personal experience with multiple expert depositions, many lawyers spend considerable time looking through everything they can on the Internet about all witnesses, including experts and those being litigated against," Blaivas says.

Blaivas says to imagine a jury being shown an image of an ED staff member who appears drunk, or an attorney reading a text aloud making fun of a patient or otherwise conveying an uncaring attitude.

"Not only do lawyers find this stuff, but if you have a complaint filed against you, medical boards can find things also," warns Blaivas. "Suddenly, a silly complaint from a patient may have some weight to it."

In an adversarial system that pits one side against the other, says Rice, the side that opposes you is going to try to use any information it can to its best advantage. "When we put things out there that could make us look less than professional, such as an impairment or something that could impact us in our professional endeavors, that makes us very vulnerable in a legal case," he says.

Rice notes that attorneys deposing him as an expert witness often will pull out articles he's authored, sometimes quoting him out of context. "They will try to convey the impression that in some way I'm not being honest or can't be trusted," he says.

Attorneys are using this same tactic with social media, says Rice, and depending on how the case is being framed, it could well become admissible evidence. "Saying anything that could impugn your integrity or professionalism can be very, very damaging," he says.

Posting *During* a Trial

In one case, a blogger made real-time posts during his medical malpractice trial using the anonymous pseudonym "Flea," notes **William Sullivan**, DO, JD, FACEP, director of emergency services at St. Margaret's Hospital in Spring Valley, IL, and a Frankfort, IL-based practicing attorney. "He made derogatory comments about the jurors in the case, the opposing attorney, and the legal system in general," he says. "In addition, he disclosed some of his attorney's trial strategy."

A colleague of the plaintiff's attorney recognized that the posts were describing his colleague, and he notified her, says Sullivan. The following day, while on the stand, the defendant physician was first asked whether he had a medical blog, and then asked "Are you 'Flea'?" he says.

"After the defendant admitted that he was 'Flea,' the case settled for a substantial sum the following morning," says Sullivan. "Had the jurors learned of 'Flea's' contempt for them and the system, it is likely that a large verdict would have ensued."

Posts to social media sites probably will be discoverable during a lawsuit, says Sullivan. "Whether those posts may be admissible as evidence depends on whether the plaintiff can draw a link between the post and alleged malpractice," he says.

An EP who posts a picture of himself or herself partying at a bar a few hours before a scheduled shift may open himself or herself up to accusations of being intoxicated when caring for patients at work, says Sullivan.

"A 'tweet' that you 'busted another patient faking back pain to get drugs' which occurs on the same date that you missed an epidural abscess might lead jurors to think that you didn't take a patient's complaints seriously," adds Sullivan.

"The bar for admitting social media posts into evidence may be fairly low," says Sullivan. "Most defense attorneys would discourage any posting about patients."

If an EP has a strong desire to post stories about patients, he or she should change identifying information so that the patient cannot be identified, advises Sullivan. "Strongly consider whether to publish any material portraying patients in a negative light," he says.

Patients, Others May ID Themselves in Your Posts

Online posts often contain more data than were really intended, says **Michael Blaivas**, MD, RDMS, professor of emergency medicine in the Department of Emergency Medicine at Northside Hospital Forsyth in Cumming, GA, and patients may be able to pick themselves out.

Other individuals may see the post, and know who the patient is, says **Corey M. Slovis**, MD, professor and chairman of the Department of Emergency Medicine at Vanderbilt University Medical Center in Nashville. "Many of us let others know that we had to go to the ER, so our identities could easily be ascertained in certain circumstances," he says.

William Sullivan, DO, JD, FACEP, director of emergency services at St. Margaret's Hospital in Spring Valley, IL, and a Frankfort, IL-based attorney, says he is unaware of any cases involving EPs sued for posting information on social media sites. "If legal liability ensues from posting information to social media sites, most likely it will be a result of privacy violations," he says.

Sullivan says to remember that there is a high likelihood that others will be able to find posts that you make to social media sites, even if you remove the posts. "The Google search engine crawls sites and keeps a cache picture of many of the sites it crawls," he says.

Websites such as the Internet Archive Wayback Machine also save multiple previous versions of websites, says Sullivan, adding that anyone who is able to view your posts on Facebook or Twitter is

also able to print or copy your posts.

Health care workers may be tempted to post information about their coworkers, their department, their supervisor, or their hospital on social networking sites, notes Sullivan. "General statements probably aren't harmful, but posting negative or untrue statements are more likely to draw attention," he says.

If you interact with coworkers online, it would be very easy for someone to print out a copy of negative information you posted and distribute that information to your boss or to the hospital CEO, Sullivan adds.

"Even if you delete offensive posts, others may have copied or printed them prior to their deletion," he says. "A general rule that some lawyers use is to avoid posting anything that you wouldn't want seen written on a billboard and attributed to you."

Blaivas says that it's also important to consider the potential legal impact of social media use of *other* ED staff members.

Although EPs will be held to a higher standard personally and are more likely to be sued, says Blaivas, hospital staff are tied to the hospital, which has "deep pockets" in the eyes of lawyers. "In addition, poor publicity from someone's site can negatively impact business for the ED and hospital," he says.

Sources

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Online Postings Give Opposing Counsel Edge

Access to Damaging Personal Info

Today, it is standard practice for attorneys to do an Internet search on any adverse party and witness, according to **Robert D. Kreisman**, a medical malpractice attorney with Kreisman Law Offices in Chicago.

In medical negligence cases, these searches typically return basic information, such as a physician's medical training, a hospital or clinic's address and phone number, or the medical specialties of a physician or a nurse, says Kreisman.

However, says Kreisman, with the advent of social media websites, opposing counsel could find out much more personal information about an adverse party or witness.

"For example, Twitter could provide information on what the party was doing on or leading up to the date of the incident," says Kreisman.

If a physician uses Facebook or LinkedIn to discuss medical issues with his or her peers, Kreisman says it is possible that the opposing counsel could discover conversations or comments about issues raised in the case.

"These social media sites could provide opposing counsel with an insight into a witness's thought process, psyche, and personality, even before encountering the witness," says Kreisman. "This access would give counsel an edge in both discovery and at trial."

Is It Admissible?

There is no question that an EP's online posts are all discoverable, says **Michael Blaivas**, MD, RDMS, professor of emergency medicine in the Department of Emergency Medicine at Northside Hospital Forsyth in Cumming, GA.

"I have seen things make it into depositions and testimony already," he says. "In fact, unlike previous lawsuits which can be kept off the record in some states, there is no protection from an editorial on your Facebook page blasting a patient for being stupid, drug-seeking, or some other thing."

In order for social media posts to be admissible at trial, however, there needs to be a connection with the issues in the lawsuit, says **William Sullivan**, DO, JD, FACEP, director of emergency services at St. Margaret's Hospital in Spring

Valley, IL, and a Frankfort, IL-based attorney.

"This is a question of law to be decided by the judge," says Sullivan. "The jury will never hear about the social networking activity if the judge decides there is no nexus."

As more and more physicians and medical professionals become involved in social media websites, whether Twitter, Facebook, or LinkedIn, questions of whether information posted on these sites can be admissible at trial "have become much more relevant," according to Kreisman.

Case Law in Flux

The question is whether opposing counsel should be allowed to access and use information obtained via social media for purposes of cross-examination and impeachment at trial, says Kreisman. Kreisman notes that the New York State Bar Association recently allowed that information gained through social media websites may be used to impeach a witness at trial.[1]

"This information can only be used if it is available to the public," notes Kreisman. "Therefore, if the opposing counsel obtained the information by 'friending' the witness or directing another party to do so, then that information would not be admissible in a New York courtroom."

Likewise, a Philadelphia bar association has commented on the admissibility of information obtained from private social media sites, such as Facebook or LinkedIn, that require "friending" to see a user's complete profile, says Kreisman.

The association mandated that attorneys cannot ask a third party, whom the witness would not recognize as being connected with the lawsuit, to "friend" an adverse witness in order to obtain evidence, he reports.

"But the bar association did state that an attorney could use his or her real name to 'friend' the witness, and attempt to obtain the information openly and honestly," he says. "Attorneys can subpoena this information during the discovery portion of the lawsuit."

Kreisman also points to an Indiana court ruling that social media information is subject to the basic rules of discovery. The court rejected arguments that its production violated a party's privacy by stating that "a person's expectations and intent that her communication be maintained as private is not a legitimate basis for shielding those communications from discovery."[2]

Illinois operates under Supreme Court Rules 213 and 214 for discovery by written interrogatory and production of documents, notes Kreisman. "There is no specific rule on the subject of discovery of writings posted on a social media platform," he says. "But the case law would support production of these materials, regardless of their source, even from social networks."

This may be because the way people communicate, professionals included, has changed dramatically in recent years, says Kreisman. "In Illinois, the courts would insist that professionals reasonably expecting litigation to ensue should be aware that e-mails, blog posts, and social network writings are likely to be requested in discovery, and must be preserved or else face spoliation consequences," he adds.

Retrieving information from social media sites is not necessarily easy for a plaintiff's attorney to do, says Kreisman. He notes that sites such as Facebook and MySpace will produce information only with the user's consent or by court order.

Although the Indiana court held that the production of social media information did not violate a party's privacy in *Equal Employment Opportunity Commission v. Simply Storage Management., LLC*, a California court held that Facebook and MySpace were prohibited from producing such information under the federal Stored Communications Act, notes Kreisman.[3]

"Subpoena power will, in many jurisdictions, trump opposition to this discovery," says Kreisman. "Furthermore, those who do post on a blog or on the 'wall' of a Facebook friend must be aware that these writings can be discoverable and used at a trial."

What is clear, says Kreisman, is that the law surrounding production of social media information is still in flux. The trend, he says, seems to be to permit its use at trial as long as the material meets the evidentiary requirements of relevancy and materiality.

"There are no magic guidelines for keeping information private," says Kreisman. "The best defense is to practice common sense and discretion, operating from the assumption that one day the information posted could be used at trial."

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Ambulance Diversion: Solution or Problem?

By Timothy A. Litzenburg, Esq., and N. Beth Dorsey, Esq.; Hancock, Daniel, Johnson & Nagle, P.C., Richmond, VA

As ED overcrowding becomes more widespread, the companion problem of ambulance diversion becomes increasingly acute at EDs across the nation.

Reasons for Ambulance Diversion

Ambulance diversion is the phrase commonly used to describe the practice of turning away patients from an ED when it is overcrowded and sending the emergency vehicle to an alternate hospital. The practice originally was intended to provide quick relief to a full ED, and served to protect current patients when the arrival of another patient would jeopardize the quality of care.[1] Federal regulation defines "diversionary status" as a hospital that "does not have the staff or facilities to accept any additional emergency patients."[2] This practice, unfortunately, has become all but standard operating procedure at some institutions.[1]

Initially, the health care community welcomed ambulance diversion as an effective solution to ED overcrowding.[3] Diversion was one way to ease the burden on EDs created by the inappropriate use of emergency medical care by patients without urgent medical conditions.[3] Moreover, in the late 1980s and early 1990s, the United States experienced a dramatic downsizing of hospital capacity. In 1981, America had 1.36 million hospital beds; that number dropped to 829,000 by 1999. During this same period, ED visits increased (14% between 1992 and 1999).[3] This led inevitably to overcrowding, including the practice of "boarding," or retaining admitted patients in the ED as they waited for a hospital bed. In turn, ED patients experienced longer wait times, and some left the hospital without being seen.[1]

In response to this chronic problem, and sometimes in response to temporary emergencies such as mass-casualty events, the emergency medicine system adapted to redistribute and transport patients. Most commonly, an institution diverts incoming ambulances when its ED has exceeded its capacity to care for patients. A hospital might also divert patients to higher-level facilities when medically indicated; for example, to another hospital that has better radiology equipment or on-call specialists. Diversion can happen simply as a result of patient preference as well.[4]

As recently as 2000, the U.S. Surgeon General and Joint Commission made statements to the effect that diversion was a cyclical problem that would resolve itself, and that it did not need a specific policy response.[5] Contrary to these expectations, however, diversion has not resolved itself. In fact, diversion has become standard practice in many communities. One 2006 study found that 45% of hospitals practiced ambulance diversion, and that they spent an average of 3% of their operating time in diversion mode.[6] As use of ambulance diversion has become more widespread, hospitals and policymakers have realized that the practice is not without its own risks.

Pitfalls of Ambulance Diversion

Although the diversion of patients with urgent conditions to other hospitals can serve to lighten the burden on the diverting institution's ED, it also can pose dangers to patient care and safety. The most obvious and critical of these dangers is the delay in treatment that the diverted patient experiences if the distance between the alternate hospital and the diverting hospital is significant.

A review of civil lawsuits involving EDs indicates that diversion of patients to other hospitals can result in critical delays in treatment, and can even contribute to patient deaths. In one high-profile case in Ontario in 2000, an 18-year-old man experienced severe respiratory distress and his family called 911. An ambulance arrived 9 minutes later, just as the man collapsed and experienced convulsions. The nearest ED was on "critical care bypass," diverting would-be ED patients to other hospitals. The patient was asystolic by the time he reached an available ED. Normal rhythm was established in the ED, but the man had irreversible brain damage. He died two days later.[7]

Ambulance diversion also can lead to the misallocation of EMS resources. As emergency vehicles are forced to travel longer distances, there are fewer vehicles available to the community at a given time.[4] Furthermore, while the practice may alleviate overcrowding at the diverting hospital, it is likely to contribute to overcrowding at the receiving hospital, negatively impacting patient care there.[6]

Finally, ambulance diversion can have a negative impact on a hospital's revenues. One study found that the net revenue from patients arriving

at the ED by ambulance was nearly three times higher than that of patients arriving by other means.[8] When a hospital takes measures to reduce diversion, one study concluded that it gains an average of $1,100 per hour for each hour of diversion avoided. Another study found that a suburban teaching hospital lost as much as $5,845 per hour of ambulance diversion.[9]

Pertinent Law and Federal Case Studies

The Emergency Medical Treatment and Active Labor Act (EMTALA) governs any situation where a patient "comes to the emergency department" seeking "examination or treatment for a medical condition."[10] Federal regulations state that a patient is not considered to have come to the ED if he is in a non-hospital-owned ambulance and is not on hospital property. The hospital may direct the ambulance elsewhere if it is in "diversionary status."[2] If an ambulance is diverted to another hospital prior to arriving at the diverting hospital, it would seem that EMTALA would not apply to that patient. However, two federal courts have ruled that, if done improperly, ambulance diversion can be a violation of EMTALA.

In 2001, the Ninth Circuit Court of Appeals ruled that a defendant hospital violated EMTALA by diverting a patient when the hospital was not in "diversionary status" at the time. The plaintiff experienced shortness of breath at his workplace, and his coworkers called for an ambulance. The ambulance picked up the patient and departed for the nearest ED. En route, ambulance personnel contacted the ED by radio. They relayed that the patient was in severe respiratory distress. One of the EPs directed that the ambulance take the patient to a government hospital, rather than proceeding to his ED. The ambulance driver complied, and the patient's condition deteriorated en route to the government hospital, which was further than the originally planned ED. He died less than an hour after arrival. His family sued the hospital and the EP group. The court overturned a lower court's ruling of summary judgment for the defendants, finding that where the hospital was *not* in "diversionary status," it could not divert the patient as it had done, which violated EMTALA.[11] The court held that a hospital may divert ambulances "only when the diverting hospital has a valid, treatment-related reason for doing so," such as an ED that could not safely accept additional patients.

More recently, in 2008, the First Circuit Court of Appeals ruled that when an ED turned away a patient in an ambulance based on financial considerations, that patient had "come to the emergency department" for EMTALA purposes.[12] The patient, who was carrying an ectopic pregnancy, experienced severe abdominal pain and vomiting. Her coworkers called for an ambulance, which collected her and departed for the hospital where her obstetrician practiced. Ambulance workers called the hospital en route, and spoke to the ED director, who inquired whether the patient had perhaps induced an abortion and further inquired as to her medical insurance coverage. Receiving no assurances from the physician that the hospital would accept her, the ambulance crew took the patient to another hospital. The patient sued the hospital that turned her away. The court ruled that EMTALA applied because the patient was en route to the hospital and the hospital had been notified.

State Law and Case Studies

State laws require physicians to comply with the standard of care, which is generally defined as what a reasonably prudent physician would do in the same or similar circumstances. EPs must carefully consider their duties to existing patients as well as prospective patients when making decisions regarding possible diversion. State courts, for example, have imposed liability in cases where patients were diverted for improper purposes.

For example, in a 1988 Georgia case, a man was injured in an automobile accident and EMTs responded. The EMTs requested a medivac helicopter to transport the patient to a burn center in a nearby city. The local hospital authority, which did not own the burn center, instead directed the helicopter to its own nearby hospital, which did not have the capability to treat severe burns. Once the patient arrived, hospital personnel realized that he required the care of a burn center, but encountered some difficulty in transporting him, including a helicopter crash (with no injuries). The man died as a result of his burns, and his estate sued the hospital authority for wrongful diversion. A jury awarded the estate $1.31 million.[13] The hospital authority could have avoided liability by allowing the helicopter to transport the patient to a burn center directly from the automobile accident scene.

To avoid liability at both the state and federal level, physicians and EDs must make careful choices when deciding whether to divert incoming emergency vehicles. Patients should be directed to other nearby hospitals only when the diverting facility is on diversionary status because it does not have the staff or facilities to accept any

additional emergency patients. Preferential routing of certain patients to an ED for financial reasons, or diversion due to lack of insurance, must never occur.[14]

Ideas for Improvement

There is no silver bullet to fix the problems of overcrowding and ambulance diversion, but studies have found that common-sense approaches are most effective. Measures that improve hospital efficiency or patient flow are also helpful, such as improving patient triage through physical space modifications of the ED area itself.[1] Critical decision units, or "23-hour observation units," have been shown to help reduce diversion. Such units, under the control of the ED but not physically part of its space, allow physicians to monitor patients without keeping them in the ED or admitting them to the hospital floor, thereby freeing up ED beds.[15] Observation units have been linked to a 40% reduction in ambulance diversion.[16] Diversion is strongly connected to boarding patients in the ED, and any efforts to decrease the latter will have a positive effect on the former.[17]

Local EMS agencies can limit the time a hospital can be on diversionary status, or establish a minimum time a hospital must stay off diversionary status. This approach relies heavily on the cooperation of EDs, but some EMS agencies have found it highly effective.[1]

Advances in information technology have provided an opportunity for lessening the potential harms of ambulance diversion. Some communities, such as Milwaukee and Syracuse, have begun to use real-time information sharing systems that constantly monitor the status of services in the area, including diversionary status. Using the system, hospitals' diversionary status changes according to guidelines and automated data reporting.[18] These systems have the capacity to disseminate urgent data to all area hospitals simultaneously.[19] This serves to decrease confusion and instantaneously optimizes the allocation of resources in the community, skipping the step of ambulance diversion. Furthermore, it forces hospitals to take a problem-solving and cooperative tact, rather than simply turning a patient away.

At least one state has taken the step of prohibiting diversionary status, with positive results. In 2008, Massachusetts announced the mandatory elimination of routine ambulance diversion. In response to the ban, hospitals changed their procedures to improve efficiency, taking measures such as hiring nurse practitioners, drawing labs earlier, and developing a "surge pod" for ED patients awaiting inpatient beds.[20]

Finally, increased funding could reduce the burden on EDs and thus decrease diversion. EDs and ED physicians suffer a low reimbursement rate. To maintain the quality of emergency care, state and local governments might provide more reimbursement to hospitals that treat a large portion of uninsured patients.[21]

Conclusion

ED overcrowding can lead to ambulance diversion, which, while ameliorative, is a problematic policy. Rather than send patients elsewhere in response to crowding, EDs and emergency physicians should work to address the problem of crowding itself through improving patient flow and efficiency. Ambulance diversion is likely to remain in practice for some time, but an ED must never divert a patient for any reason other than patient safety.

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Your ED Patient Should Have Been Transferred, But Wasn't?

Document Your Reasoning

If there was the potential for a better outcome if a patient was transferred, and the patient was harmed and can show that you breached the standard of care, a successful lawsuit could result, says **Michael Blaivas**, MD, RDMS, professor of emergency medicine in the Department of Emergency Medicine at Northside Hospital Forsyth in Cumming, GA.

Plaintiff's attorneys are well aware of Emergency Medical Treatment and Labor Act requirements and the need to transfer patients for a higher level of care, he says. "The public is also aware that transfers occur all the time, and feel it can be done without any delay," says Blaivas.

If a patient does not get surgical intervention, critical care, or cardiac catheterization in a timely manner due to failure to transfer or delay of transfer that cannot be explained by issues beyond the control of the EPs, says Blaivas, then a lawsuit can occur and be successful.

"There are cases that may be looked at closely, but while harm occurred, there was no chance for improved outcome," adds Blaivas. He gives the example of the discovery of a thoracic aortic dissection with a pericardial effusion and root involvement. "If you transfer the patient and it takes two hours to get them to the OR at the receiving facility and they die, there was little that could have been done better," he explains.

In fact, says Blaivas, "the mortality rate for these patients is so high that even if the patient presented to the receiving hospital initially, was immediately diagnosed, and went to the OR right away, they still may not have done better."

Matthew Rice, MD, JD, FACEP, former senior vice president and chief medical officer at Northwest Emergency Physicians of TEAMHealth in Federal Way, WA, says that a patient could have a successful lawsuit if the appropriate legal criteria are met and the transfer is possible and reasonable.

The patient's personal desire for transfer, a poor outcome because of failure to transfer, and knowledge by the ED provider of the need to transfer the patient for appropriate services are factors that increase the likelihood of a successful lawsuit, he says.

Rice gives the example of a chest pain patient who requires emergency cardiac catheterization, but instead is admitted to cardiology for catheterization the following day because the hospital doesn't have a 24-hour catheterization lab.

Another example involves referral to a medical facility or medical provider that meets "economic concerns" but is not the highest standard of care, says Rice. "Transferring a patient to a more distant facility for time-dependent treatment because of 'insurance,' instead of a closer medical facility with equivalent resources, has risk if there is a poor outcome," he warns.

To reduce risks, Rice says to document reasons for "keeping" or transferring the patient, with risks and benefits of each clearly outlined and explained to the patient for his or her consent.

"Knowingly keeping a patient at the 'home' hospital, when the ED provider knows that the accepting physician is *not* the appropriate provider for the patient's problem, and there is a bad outcome with the patient" can result in a successful lawsuit, says Rice.

There is a huge range of capabilities for different EDs across the country, notes **Emory Petrack**, MD, FAAP, FACEP, a medical-legal consultant and principle of Shaker Heights, OH-based

Source

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Petrack Consulting. "Examples range from large tertiary Level 1 trauma centers to small community departments with low volumes," he adds. "The key is to be aware of your department's resources and limitations."

Petrack says that a good example involves pediatric emergency care. A common medical legal risk is failing to transfer and admit an infant or child who has a disease process beyond the resources of a community ED, he says.

"If something significant is just 'not right,' such as vital signs that are significantly abnormal with an otherwise well-appearing child, it is prudent to arrange admission, at least for observation," says Petrack. "If the hospital does not have pediatric inpatient beds, the child should be transferred to an appropriate facility."

ED *Not* a Stroke Center? Patient May Sue for Failure to Transfer

With some hospitals being designated as demonstrating excellence in the care of stroke patients, does this mean a patient can successfully sue the ED if he or she is *not* treated at one of those facilities?

A patient's lawsuit may involve the failure to transfer a patient to a stroke center where tissue plasminogen activator (tPA) or another therapy is available, notes **John Burton**, MD, chair of the Department of Emergency Medicine at Carilion Clinic in Roanoke, VA.

"That doesn't mean that it's standard of care, from a legal standpoint, that patients have to be treated at those hospitals," says Burton. "But it *does* mean that every ED should be asking the question, if they are a stroke center, 'What are the standards we should be held to?' And if you are *not* a stroke center, what are the ED's processes for getting patients to stroke centers in their area?"

Well Thought-out Plan

The ED and the hospital need to decide if they are going to engage in providing the thrombolytics and admit the stroke patient to their own facility, or transfer the patient to a receiving hospital, says **Matthew Rice**, MD, JD, FACEP, an EP with Northwest Emergency Physicians of TEAMHealth in Federal Way, WA. Regional programs are another option, he adds, with smaller hospitals consulting with a stroke center as to whether they should provide thrombolysis.

"From a risk perspective, that is somewhat protective of the smaller hospitals, because they have regional experts consulting as to what circumstances it should or should not be given," says Rice. "You are basically conferring some of the risk to consultants, for 'Should we give this or not?'"

Robert B. Takla, MD, FACEP, chief of the Emergency Center at St. John Hospital and Medical Center in Detroit, MI, reports that his facility goes beyond even the 4.5 hour extended treatment window for tPA in some cases, with the use of intra-arterial tPA.

"We keep pushing the envelope on this one. We might even be able to give therapy at any point in time," says Takla. Other possible options for stroke patients include specialized CT perfusion scans and endovascular procedures where intra-arterial tPA is provided at the site of the lesion.

"If there is a stroke center in your community, and you are not practicing at that center and you are caring for a stroke patient, then a process should be clear," says Burton. "Do you move that patient to the stroke center, or do you continue taking care of them in your hospital?"

Telemedicine May Reduce Risks

Smaller hospitals potentially can reduce their liability risks by providing telemedicine services, according to **Hartmut Gross**, MD, a professor of emergency medicine at Medical College of Georgia in Augusta. Gross is co-founder of REACH (Remote Evaluation of Acute isCHemic stroke), which provides telemedicine services to 16 hospitals, including giving tPA with consultation over the Internet.

"We make a recommendation. That is documented and becomes part of the patient's medical record, regardless if they are transferred or not," says Gross. "If I am doing the stroke consult and I am the person making the recommendation, my name is now on that chart. If there is a bad

outcome, I am going to court, and that's only fair." The REACH consultants have done more than 1,200 consultations with more than 270 tPA administrations. Without telemedicine capability, he says, "those numbers would have been basically zero."

Gross notes that Georgia recently passed legislation mandating that hospitals either subscribe to a stroke network or have patients diverted by emergency medical services to the nearest stroke-capable hospital.

"The idea is that *any* patient could be within 30 minutes of stroke care, regardless of where they live," says Gross.

Regardless, notes Gross, it still takes time to transfer the stroke patient. "You may be lucky and have an ambulance to transfer the patient to a not-too-distant place and the stars all align properly," says Gross, but in other cases, transport times might be long.

"Even waiting on a helicopter, you are going to lose time," says Gross. "Even if you give the tPA right there on the helideck, the patient is usually out of the window and you are too late. If you can give tPA rurally, then the time monkey is off your back."

Standardize Processes

Burton notes that the standard of care for trauma patients has evolved in recent years. "We've made a very clear decision in the last 30 years in emergency medicine, that if you have a high-acuity trauma patient, that patient needs to go to a Level 1 trauma center," says Burton. "That means if you practice at a Level 1 trauma center, the way you take care of patients has certain processes. And if you don't, you need to standardize the processes for getting patients to Level 1 trauma centers."

Likewise, says Burton, the EP needs to have a well thought-out plan for the care of stroke patients in their specific ED.

A stroke patient doesn't necessarily have to be transferred to a stroke center, says Burton. "But you *do* need to have a set of processes for how to treat those patients, and when you might move them to a stroke center," he says. "That is something that *every* ED has to consider."

Sources

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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. ■

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

8. Which is *true* regarding the admissibility of information obtained from private social media sites used by emergency physicians (EPs), according to Robert D. Kreisman, a medical malpractice attorney with Kreisman Law Offices?
   A. There is no existing case law supporting the discoverability of writings posted on a social media platform.
   B. Social media posts will always be admissible, regardless of any connection with the issues in the lawsuit.
   C. Information gained through social media websites can never be used to impeach a witness at trial.
   D. There is an trend toward permitting the use of information gained through social media websites at trial, as long as the material meets the evidentiary requirements of relevancy and materiality.

9. Which is *true* regarding practices to reduce liability risks of EPs utilizing social media?
   A. Personal information posted by EPs about themselves that is not relevant to issues in the lawsuit cannot be admitted as evidence.
   B. If it was not legal for an EP to post specific information about a patient, then the post is not discoverable.
   C. Plaintiff's attorneys can use personal postings by ED physicians to raise concerns about staff including ethics, competence, drug abuse, or alcohol abuse.
   D. An EP's posted comments on another individual's blog or Facebook page are not discoverable, as long as that individual is not directly involved in the litigation.

10. Which is *true* regarding lawsuits involving an EP's failure to transfer a patient, according to Michael Blaivas, MD, RDMS, professor of emergency medicine in the Department of Emergency Medicine at Northside Hospital Forsyth?
    A. It is not advisable for an EP to document the risks and benefits of transferring the patient.
    B. If there was potential for a better outcome if a patient was transferred, and the patient was harmed and can show that the standard of care was breached, a successful lawsuit could result.
    C. It is now the legal standard of care for patients to receive treatment at a stroke center where tissue plasminogen activator or other therapies are available.
    D. Legal risks for smaller hospitals are clearly increased if a stroke center is consulted as to whether they should provide thrombolysis to a patient.

Answers: 8. D, 9. C, 10. B.