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Florida Set for Showdown on Constitutionality of Noneconomic Damages Caps in Medical Malpractice Cases

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The 11th Circuit Court of Appeals ruled Florida's cap does not violate the federal Constitution, but punted whether the cap violates the Florida Constitution to the Florida Supreme Court.

The Case of McCall v. United States[1]

After a two-day "bench" trial (no jury), a United States district court judge held the United States liable for causing the death of Michelle McCall from negligent peripartum and postpartum care she received from the medical staff at a U.S. military hospital.[1,2]

The court awarded Ms. McCall's estate $980,462.40 in economic damages and $2 million in noneconomic damages. However, the court then applied Florida's statutory cap on noneconomic damages for medical malpractice claims, which had been enacted as part of the state's tort reform of 2003. Consequently, the judge limited the estate's recovery of noneconomic damages to $1 million.[3]

The estate appealed the decrease in its monetary damages to the federal appeals court, asserting that Florida's limitation on noneconomic damages violated the United States Constitution as well as the Florida Constitution.

The 11th Circuit Court of Appeals ruled that the cap did not violate the U.S. Constitution and did not violate parts of the Florida Constitution, but it left undecided whether the cap violated other aspects of the Florida Constitution. Instead, it booted those issues to the Florida Supreme Court for resolution.[1]

Florida's statute provides that for a personal injury or wrongful death claim arising from the medical negligence of practitioners (typically doctors):

- Regardless of the number of practitioner defendants, noneconomic dam-

ages shall not exceed $500,000 per claimant, and no practitioner shall be liable for more than $500,000 in noneconomic damages, regardless of the number of claimants.

• However, if the negligence resulted in a permanent vegetative state or death, the total noneconomic damages recoverable from all practitioners, regardless of the number of claimants, shall not exceed $1 million.

• The total noneconomic damages recoverable by all claimants from all practitioner defendants shall not exceed $1 million in the aggregate.[3]

The statute includes a similar provision for claims against nonpractitioners (hospitals). That provision limits noneconomic damages to $750,000 per claimant, or $1.5 million in the aggregate recoverable by all claimants against all nonpractitioner defendants.[4]

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The court noted that Florida's statutory cap on noneconomic damages was rationally related to a legitimate governmental purpose; the legislature had specifically created the cap in an effort to make malpractice insurance easier to obtain and reduce the cost of medical care.[5]

The plaintiffs had argued that the cap lacks a rational basis because the Florida legislature "had no objective, factual basis for believing" that a cap on noneconomic damages for medical malpractice claims would reduce the cost of medical malpractice insurance. The court found no merit in this argument, pointing out that before enacting the cap, the Florida legislature's Select Committee specifically prepared a report on the issue.[6]

The Florida legislature reported that a recent, dramatic increase in medical malpractice liability insurance premiums had increased the cost of medical care and decreased the availability of malpractice insurance.[7] The legislature observed that "[t]he primary cause of increased medical malpractice liability insurance premiums has been the substantial increase in loss payments to claimants caused by tremendous increases in the amounts of paid claims."[8]

Furthermore, before issuing the report, the legislature held public hearings, heard expert testimony, and reviewed a separate report prepared by Governor Jeb Bush's Task Force on Healthcare Professional Liability Insurance. The task force report set forth that health care providers were changing the scope of their practice, leaving Florida, or retiring because of escalating medical malpractice premiums. The task force recommended that the legislature create a "per incident" medical malpractice cap on noneconomic damages to remedy the problem.[1]

Additionally, the task force determined that, "Florida's medical malpractice insurance crisis presented an overpowering public necessity requiring the adoption of the liability caps."[8] The court noted it is not the role of the judiciary to second-guess the wisdom, fairness, or logic of the choices made by the legislative branch, as long as the legislature identified a legitimate governmental purpose in passing the statute. In this case, that purpose was to ensure the availability of quality healthcare by controlling the cost of medical malpractice.[9,10]

However, the court then noted that a number of the plaintiff's challenges to the cap's constitutionality under Florida law had not been adequately settled in the Florida courts, so sufficient legal precedent did not exist for it to address those issues. Therefore, the appellate court shuffled

those issues over to the Florida Supreme Court for adjudication.[11,12]

Now it will be up to the Florida Supreme Court to determine if the statutory cap on noneconomic damages violates equal protection, right to jury trial, right to access the courts, and the separation of powers guaranteed by the Florida Constitution.[13,14]

Florida Supreme Court

The battle in the Florida Supreme Court promises to be a knock-down melee. Groups such as the Florida Justice Association, AARP, the AFL-CIO, AFSCME, and the American Bar Association recently filed briefs contending the $1 million cap on pain-and-suffering damages is unconstitutional.[15]

On the other side, Florida Attorney General Pam Bondi and a wide range of medical groups, including the Florida College of Emergency Physicians, have indicated they will file briefs in support of the law.[15] Supporters have long contended that noneconomic damages caps are necessary to hold down medical malpractice insurance costs for physicians and other health care providers.

In its brief, the American Bar Association opposes noneconomic damage caps because they "discourage lawyers from taking meritorious cases where economic damages are low and thus undermine the ability of a significant number of injured persons to seek redress in the courts."

The 2003 medical malpractice revamp incited one of Tallahassee, FL's most notorious political fights of the past decade. Physicians and former Governor Jeb Bush pushed for an even lower cap on noneconomic damages, $250,000, which was a lightning-rod issue during the debate. The legislature compromised, after many contentious clashes, finally settling on the $500,000 or $1 million limits, depending on the circumstances and number of claimants, as noted earlier.[3]

Florida Legislature

It is not only the McCall case that could spark renewed tort reform wars in Florida; the legislature and new Governor Rick Scott recently upped the ante, enacting several additional laws to protect physicians and healthcare facilities against patient lawsuits.[16]

The most notable ones take effect October 1 and include the following:

Expert Witness Restrictions and Discipline.[16]

- Any physician who provides expert testimony regarding the prevailing professional standard of care must be either: 1) licensed in the state of Florida; or 2) obtain in advance an "expert witness certificate" from the Florida Department of Health.
- The medical boards are granted the power and authority to discipline any expert witness who provides deceptive or fraudulent expert witness testimony. This includes those physicians licensed in state and those testifying under an expert witness certificate.
- Additionally, any expert witness who submits the pre-suit-verified expert medical opinion is no longer immune from discipline.

This statute fixes a glitch in the Florida medical malpractice system, whereby out-of-state expert witnesses could enter Florida and generate huge fees by providing "less-than-accurate" testimony, knowing they could do so without being held accountable in any meaningful way. The new requirements apply equally to experts for both sides, not just plaintiffs' experts. Florida did not go as far as some states, which actually require all physicians to be fully licensed in-state in order to testify in state malpractice cases.[17]

Limited Medicaid Liability

The legislators passed three Medicaid bills capping pain-and-suffering damages. They limited the amount of these noneconomic damages, which could be assessed against providers who treated Medicaid patients at $200,000 for physicians, at $250,000 for nursing homes, and $300,000 for hospitals, unless the provider acted in bad faith, with malicious purpose, or with willful and wanton disregard for human rights, safety, or property.[18]

Reportedly, lawmakers made the changes to convince hospitals and physicians to go along with the legislature's plans to revamp Medicaid into a managed care program in the state.[19]

Extended Sovereign Immunity

The law also limits lawsuits against teaching hospitals and faculty physicians in the state by extending the state's "sovereign immunity" protections to teaching institutions, which caps all damages (not just noneconomic damages) at $100,000 per person and $200,000 per incident.

Limits Federal Influence in State Malpractice Cases

The law disallows federal standards or regulations into evidence that establish the medical pro-

vider breached the prevailing professional standard of care. Thus, breach of, or failure to comply with, any federal requirement is not admissible as evidence in a medical negligence case. This obviously is aimed at heath care reform, the Accountable Care Act, but could also potentially prevent government sanctions in EMTALA proceedings from being entered into civil court as evidence the hospital violated EMTALA.

Excludes Insurance Determinations as Evidence of Breach in the Standard of Care

No longer is information from an insurer's reimbursement policies, or reimbursement determination regarding medical care provided to a plaintiff, admissible as evidence against a provider. For example, Medicare's decision to refuse to pay a hospital for treatment of a "never event" would not be admissible to show a breach of the professional standard of care.

Forces Plaintiffs to Release "Protected Health Information"

Plaintiffs will now be required submit a form for the release of protected health information that is potentially relevant to the claim of personal injury or wrongful death, whenever notifying a prospective defendant of their intent to sue for malpractice. This will make it much easier for a physician to obtain the patient's health care information early on in a malpractice suit.

Furthermore, if the plaintiff does not, in good faith, complete the new pre-suit form, the "authorization for release of protected health information" form, the court can dismiss the claim and assess attorneys' fees and costs against the plaintiff.

Enhances Physicians' Opportunities to Control the "Right to Settle" a Malpractice Claim

Insurance policies for medical malpractice coverage will now be required to state clearly whether or not the insured physician has the exclusive right to veto of any insurance company's intent to settle a case or admit liability (with its National Data Bank implications) on behalf of a physician. Additionally, the law repeals the requirement that a physician, in the insurance policy, must authorize the insurer to make this decision without the permission of the insured physician, if the settlement is within the policy limits.

Proponents of tort reform trust that these statutory changes will further decrease the number of medical malpractice suits filed in Florida. The Florida Office of Insurance Regulation reported that after the series of sweeping changes made in 2003 by Governor Jeb Bush, which included the caps on noneconomic damages, both the number of lawsuits and the size of payouts fell by about 14%, and the total insurance premiums paid by physicians dropped even further, around 36%.

Florida has the highest medical malpractice premiums in the nation and, expectantly, ranks among the states with the greatest amount in paid malpractice claims. The average liability premium for an obstetrician is $200,000 per year, which equates to approximately $2,000 of the delivery cost for each baby funneled straight to paying malpractice insurance premiums.[17]

The American Tort Reform Association (ATRA) pronounced 2011 as the "most productive year for enactment of meaningful state civil justice reforms in recent memory."[20] Indeed, more than 30 new tort reform measures have been passed already in the states this year, including "big wins" in Alabama, Arizona, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, and Wisconsin.[20-23] But there have been big losses recently, too, most notably the Supreme Courts of Illinois and Georgia struck down caps on noneconomic damages.[24]

The American people consistently believe that limits on noneconomic or pain-and-suffering damages are a "good thing." Harris Interactive polling data show that nearly two-thirds of Americans support full payment for medical expenses and economic losses, coupled with reasonable limits on pain-and-suffering damages for patients harmed due to medical negligence.[20]

ATRA president Tiger Joyce summed up the Harris poll stating: "Such strong support is likely attributable to the fact that better than seven in 10 Americans, according to the survey, believe their access to affordable, high-quality health care is threatened because medical liability costs are forcing good doctors out of medicine. And nearly six in 10 believe excessive and unpredictable medical liability lawsuits are a significant factor in driving health care costs higher. All of which explains why 58% of Americans say they want Washington lawmakers to support comprehensive medical liability reform, while only 23% oppose such reform."[20]

One recent research study strengthens the case for liability reform, finding that states with caps on noneconomic damages have medical liability

premiums, on average, at least 17% lower and the supply of physicians in high-risk specialties from 4% to 7% higher than those states without non-economic damages caps.[25]

Even the federal government is paying attention to the impact of tort reform. During the end game of the recent federal debt ceiling negotiations, both the Executive Office of the President and the Congressional Research Service requested malpractice rate survey data to examine the cost-decreasing effects of medical liability reform on the provision of health care.[20]

On more than one occasion, the non-partisan Congressional Budget Office (CBO) has opined that significant cost savings could result from inserting malpractice liability reform into the federal health care programs, such as Medicare and Medicaid. The CBO projects that such liability reform would generate savings of $13.5 billion in the first five years after enactment, and $54 billion over a 10-year time period.[26,27]

Governors and state lawmakers of both parties, as well as local business leaders, see vigorous job growth in tort reform states such as Texas,[28] but just the opposite in highly litigious states such as Illinois, California, and New York, where the legislative process is dominated by plaintiffs lawyers. As ATRA president Joyce opined, "One needn't be a Nobel-winning economist to understand that reasonable limits on liability promote prosperity, while expansions of liability undermine prosperity."[20]

Maybe the federal legislature will finally wake up to the economic and health care benefits of reasonable medical liability laws that have so benefited the states in recent years. ■

REFERENCES

1. McCall v. United States, No. 09-16375 (11th Cir. May 27, 2011), available at http://www.ca11.uscourts.gov/opinions/ops/200916375cert.pdf.
2. Plaintiffs sued the U.S. under the Federal Tort Claims Act ("FTCA"), 28 U.S.C. §§ 1346(b), 2671–80.
3. Fla. Stat. § 766.118(2).
4. Fla. Stat. § 766.118(3).
5. See Fla. Stat. § 766.201(1).
6. See Florida House of Representatives, Select Committee on Medical Liability Insurance Report (2003).
7. See Fla. Stat. § 766.201(1)(a).
8. See Fla. Stat. § 766.201(1)(b).
9. McCall v. United States, No. 09-16375 (11th Cir. May 27, 2011), available at http://www.ca11.uscourts.gov/opinions/ops/200916375cert.pdf (citing Hodel v. Indiana, 452 U.S. 314 (1981)).
10. See Fla. Stat. § 766.201.
11. See Fla. Const. Art. V, § 3(b)(6).
12. See Fla. R. App. P. 9.150.
13. See Fla. Stat. § 766.118.
14. See Fla. Const. Art. I & Art. II.
15. See McCall v. United States, appeal docket, No. SC11-1148 (Florida Supreme Court).
16. E.g. Florida House Bill 479.
17. See, Butler, Dr. Madelyn E. Bill Aims to Make Florida a Friendlier Place to Practice Medicine, *St. Petersburg Times*, May 19, 2011, available at http://www.tampabay.com/opinion/columns/bill-aims-to-make-florida-a-friendlier-place-to-practice-medicine/1170370.
18. Florida House Bill 7109.
19. Saunders, Jim, Court May Decide Medical Malpractice Cap, *The St. Augustine Record*, Health News Florida, August 29, 2011, available at http://staugustine.com/news/local-news/2011-08-29/court-may-decide-medical-malpractice-cap.
20. Medical Liability Monitor 2011;36(8):1.
21. See e.g., Bitterman RA. Tort Reform Takes Big Hits, But Keeps on Ticking. *ED Legal Letter* 2010;21(5):49-54.
22. See e.g., Bitterman RA. Update on State Medical Malpractice Wars — Part I of II. *ED Legal Letter* 2010;21(7):73-77.
23. See e.g., Bitterman RA. Update on State Medical Malpractice Wars — Part II of II. *ED Legal Letter* 2010;21(8):85-89.
24. Lebron v. Gottlieb Memorial Hospital, 930 N.E.2d 895 (Illinois 2010); Atlanta Oculoplastic Surgery, P.C. v. Nestlehutt, No. S09A1432 (Ga. Mar. 22, 2010); but also see Gliemmo v. Cousineau, No. S09A1807 (Ga. Mar. 15, 2010) (upholding beneficial standards of liability in emergency cases in Georgia).
25. Kane CK and Emmons DW. The Impact of Liability Pressure and Caps on Damages on the Healthcare Market: An Update of Recent Literature, 2007 American Medical Association, available at http://www.ama-assn.org/ama1/pub/upload/mm/363/prp2007-1.pdf.
26. Congressional Budget Office, Reducing the Deficit: Spending and Revenue Options, Pub. No. 4212, March 2011, available at http://www.cbo.gov/ftpdocs/120xx/doc12085/03-10-ReducingTheDeficit.pdf.
27. Congressional Budget Office, Cost Estimate: H.R.5 - The Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2011, as ordered by the House Committee on the Judiciary on February 16, 2011, March 10, 2011. Available at: http://www.cbo.gov/ftpdocs/120xx/doc12095/hr5.pdf.
28. See, Bitterman RA & Fish MB. Health Care Reform: Should It Grant Physicians Immunity for EMTALA Mandated Services? *ED Legal Letter* 2009;20(10):109-113 (detailing the success of Texas tort reform).

Will Future Suits Allege Cancer From Needless ED CT Scans?

Editor's Note: This is the second of a two-part series on liability risks involving ordering of diagnostic tests in the ED. This month, we report on possible lawsuits for future cancers, strategies if patients threaten to sue because a test wasn't ordered, and liability risks specific to pediatric patients. Last month, we covered legal ramifications of deciding not to order a test, legal risks of unexpectedly abnormal results, how ED protocols can help an EP's defense, and a new quality measure that increases liability risks for EPs.

Will we someday see television ads from personal injury lawyers asking viewers if they've received needless CT scans in EDs and later been diagnosed with cancer? Researchers have estimated that 29,000 future cancers could be related to CT scans performed in the United States in 2007 alone.[1]

If low-yield, high-radiation studies are being considered for a head-injured patient, the emergency physician (EP) should thoroughly discuss the various options with the family, says **Robert I. Broida**, MD, FACEP, chief operating officer at Physicians Specialty Ltd. in Canton, OH.

"It is quite reasonable to evaluate a patient carefully, document thoroughly, provide great instructions, and avoid the unnecessary radiation exposure," he says, as long as there are reliable family members to monitor the patient after discharge. "If all of these items are present in the medical record, the case should be quite defensible, based on current medical literature."

On the other hand, says Broida, it will be quite difficult for EPs to base their defense on reluctance to order a diagnostic test due to a risk of cancer 30 years from now, if a patient has an undiagnosed epidural hematoma. When the EP doesn't order a test, it is essential that the history and physical and medical decision-making are exemplary, he says.

"Juries have a hard enough time understanding that the science says the CT is not indicated," says Broida. "They will not be forgiving if the physical exam is incomplete and there is a devastating outcome."

The older the patient is, the less concern there is about risks, adds **Bruce Janiak**, MD, professor of emergency medicine at Georgia Health Sciences University in Augusta, whereas there is a great deal of concern about the cumulative effect of radiation on younger patients. "Right now, it's theoretical, but a generation from now we could be seeing a great increase in cancers," he says.

Add Layer of Protection

When ordering a CT scan, **Sandra Schneider**, MD, professor of emergency medicine at University of Rochester (NY) Medical Center, recommends that EPs get a consent form signed or document the statement, "I have discussed with the patient that there is a small risk of cancer from getting a CT scan," or both. "Just getting a consent form won't totally protect you, but it does add a layer of protection," says Schneider. "I personally plan on doing this."

If the patient doesn't want the CT, Schneider advises documenting: "I have discussed with the patient that there is a 1 in 100 risk of subarachnoid hemorrhage. They have chosen to take that risk and not have a CT scan because of the risk of cancer."

The EP "is really between a rock and a hard place," says Schneider, when it comes to legal risks involving CT scans. "There are a number of disease entities that are very difficult to diagnose, and CT scan is very good at finding these things," she says, including subarachnoid hemorrhage. At the same time, she notes that the scans carry a risk of cancer.

"The risk is probably a 20-year risk, so we have yet to see these cases start, but I have a feeling that it may be coming," says Schneider. "The problem is going to be the cause and effect and how this plays in a jury."

Risk of Missed Diagnosis

John Burton, MD, chair of the Department of Emergency Medicine at Carilion Clinic in Roanoke, VA, reviewed three large lawsuits against EPs in a single year, each claiming that if the EP had ordered a CT scan, he or she would have found a diagnosis that ultimately killed the patient.

All were seven-figure cases, and all of the claims alleged the EP failed to get the CT scan, but the cases involved head, neck, and chest CTs, he says.

"There is a certain mentality among EPs of 'I've never been sued for ordering a CT scan,'" says Burton. "When you look at those cases, you have to say that it does look pretty improbable, particularly when the diagnoses you might pick up are life-altering."

While there is growing concern about needless ordering of CT scans because of cancer risk, this is currently an "academic argument," notes Burton. "When you are trying to decide whether to order a CT scan or not, and you really believe there may be the presence of the illness, the risk of missing the diagnosis far, far outweighs any radiation risk," he says. ■

REFERENCE

1. de Gonzalez AB, Mahesh M, Kim KP, et al. Projected cancer risks from computed tomographic scans performed in the United States in 2007. *Arch Intern Med*. 2009; 169(22):2071-2077.

What If Patient Threatens to Sue If Test Isn't Ordered?

After the actress Natasha Richardson died in 2009 from an epidural hematoma that media reports emphasized could have been diagnosed with a head CT scan, EPs were flooded with requests for the test, even for patients with very minor head injuries, recalls **John Burton**, MD, chair of the Department of Emergency Medicine at Carilion Clinic in Roanoke, VA.

"The way EPs reacted to that particular event was to order a lot of CT scans," says Burton. "They were generally unwilling to get into arguments with patients, particularly when the EPs knew that they could miss one subarachnoid hemorrhage patient amongst all those people they were refusing."

Should the EP agree to order a diagnostic test simply because a patient asks for it, to protect against the possibility of a lawsuit? "The answer to this question is probably different than it was 10 years ago," says **Ben Heavrin**, MD, assistant professor of emergency medicine at Vanderbilt University Medical Center in Nashville, TN. EPs are increasingly evaluated and, at times, reimbursed, based on patient satisfaction scores, he notes.

"Should an emergency physician counsel a patient that a test is not necessary, and should the patient still demand the test, there is an incentive to order the unnecessary test to keep the patient happy," says Heavrin. "Additionally, happy patients are less likely to sue should a bad outcome arise."

Thus, says Heavrin, patient satisfaction and the threat of litigation both drive the use of testing when it is not clinically indicated. If an ED patient demands a diagnostic test that isn't clinically indicated, Heavrin says to document that this was discussed with the patient and that the risk from unnecessary radiation outweighs the benefits of any information expected to be obtained from the test. "Not only does that provide a good defense, it is, more importantly, the right thing to do clinically to not order the test," he says.

A child with a benign abdominal examination and otherwise benign work-up for abdominal pain, for example, suffers a real risk of harm from an unnecessary CT scan of the abdomen, says Heavrin.

Identify risks on both sides of the argument so you are prepared to share this information with patients, recommends **Sandra Schneider**, MD, professor of emergency medicine at University of Rochester (NY) Medical Center. "It takes a little digging to get that information. But once you have it, you can share it with your entire group. Then, everybody is saying the same thing."

Schneider says she sees both patients who have had far too many CT scans and come in requesting another one, and patients who really need a CT scan but refuse it due to concerns about cancer. She recommends looking up previous medical records or asking patients if they've had additional scans at other facilities.

When Schneider learned that one of her patients had received 15 CT scans for chronic abdominal pain during the past several years, she convinced him to try pain medication before ordering another scan. After four hours, he reported that the pain was still present so he received the scan.

"It came back as normal, but almost nothing would dissuade him from getting the test," Schneider says. "That happens very frequently. Patients have heard stories about people having multiple tests, and it's the last one that shows where the problem is."

Good Clinical Judgment

If an ED patient demands a diagnostic test that isn't clinically indicated, **Robert I. Broida**, MD, FACEP, chief operating officer at Physicians Specialty Ltd. in Canton, OH, says that the "academic school of thought" maintains that the EP should only order what is clinically indicated based on peer-reviewed, evidence-based studies.

"In reality, many patients will simply 'shop elsewhere' and find another physician who will acquiesce," says Broida. "This ends up costing the

health care system two visits instead of one. Also, if the patient is right and the test turns out to be positive, there could be problems."

Simply ordering a test because a patient demands it is "the easy way out, but it is horribly wrong," says **Bruce Janiak**, MD, professor of emergency medicine at Georgia Health Sciences University in Augusta. When patients ask for needless tests, Janiak typically tells them: "I can't believe you would want me to do something that I think is wrong. You may need the test at some time in the future, but it is not indicated now.'

"That usually ends the conversation," he says. "Rather than order needless tests, take the time to explain to people why they aren't necessary. And if the patient says he'll sue you if you don't order the test, give them the Yellow Pages and tell them to go find an attorney."

In this scenario, Janiak says to document that you informed the patient that there is no indication for the test, and that the patient was angry and threatened to sue. However, Janiak says that in his 40 years of practice, he can count on one hand the number of patients who couldn't be satisfied. "What we don't know is what percentage of patients nod their heads, but immediately go across town to the next hospital to ask for the test," he says.

Legal Risks For "Needless" Diagnostic Tests in Children

If a moderately dehydrated child with gastroenteritis requires intravenous fluids, but is otherwise well-appearing and afebrile, the EP could "make a reasonable argument" for checking electrolytes, according to **Emory Petrack**, MD, FAAP, FACEP, a medical-legal consultant and principle of Shaker Heights, OH-based Petrack Consulting.

However, says Petrack, "One is hard pressed to argue why a complete blood count (CBC) or other testing would be needed in an otherwise healthy patient. If there is a significant abnormality, such as an elevated white count," he explains, "this could spur further unnecessary testing."

Petrack notes that there is increasing evidence that pediatric patients with mild head injuries who have not lost consciousness, do not have significant vomiting, and have a normal neurologic exam probably do not need head CTs.

"It's very important to keep up with the current literature, especially paying attention to large multi-center studies or meta-analyses, to help determine current standards of care," says Petrack.

A recent study looked at 42,412 children with minor blunt head trauma, and found that the rate of CTs was lower if patients were observed.[1] Clinical observation before making a decision regarding CT scan use seems to be a safe and potentially effective strategy to manage a subset of children with minor blunt head trauma, according to the researchers.

In terms of a single head CT scan being ordered by an EP, this should have no impact on a future lawsuit involving a cancer diagnosis, says **Nathan Kuppermann**, MD, MPH, one of the study's authors and a professor of emergency medicine and pediatrics at University of California — Davis Health System.

"There are many strategies for caring for children with minor head trauma. Some include CT scans, and others don't," says Kuppermann. "To prove that one should or should have not used a CT scan is almost impossible. There is very much clinical judgment involved."

Many Unnecessary CTs

Many pediatric patients are still receiving unnecessary head CTs, however, because EPs want to protect themselves against lawsuits, adds Petrack. "If a CT is clearly not indicated, and there is an adverse outcome, such as cancer, down the road, at some point, I suspect we will start seeing medical-legal action against providers," he says.

While Petrack says it would be very difficult for a plaintiff's attorney to prove the cancer is from a specific CT scan, the risk is believed to be at least partially dose-related. A head CT is equivalent in dosing to about 100 chest X-rays, he notes, while an abdominal CT is equivalent to approximately 400 chest X-rays. "It's a lot of ionizing radiation, and we've become particularly concerned about this exposure in growing children," he says.

While there are frequently times when it's clearly appropriate to order an abdominal CT, many situations are borderline, at best, says Petrack, and other less invasive modalities, such as ultrasound or observation, for low-risk situations, may be more appropriate.

"However, at this point, I suspect clinicians believe the risk of not obtaining a CT, with a potential near-term adverse outcome of a perforated appendicitis, outweighs the more nebulous risk of medical-legal action years down the road," says Petrack.

In a low- to medium-risk situation, Petrack has a frank discussion with a parent about the risks and benefits of CT and ionizing radiation, using as a "benchmark" what he would do if it were his

child. "I believe this generally leads to good decision making and satisfied parents," says Petrack.

Too often, however, EPs aren't even considering the risk of radiation when deciding what tests to order, says Petrack. "I see physicians sometimes ordering a complete cervical spine CT in a child who is unlikely to have a cervical spine injury, when plain films would be adequate," he says.

Good Documentation

"Anytime you order a test, you have to know why you are ordering it and what result you are hoping to see," says **Mark Meredith**, MD, assistant professor of emergency medicine and pediatrics at Vanderbilt University School of Medicine in Nashville. "If you are ordering a test just to order it, it's obviously not very good practice."

If you order a CT scan for a head-injured child because you are legitimately concerned, says Meredith, "then I think that legally you are covered, assuming you are following the guidelines that are out there. Obviously, we don't want to do a CT scan on every child who hit their head."

As for lawsuits involving future cancers in children, Meredith says that good documentation on why the EP ordered the scan and what concerns the EP had would become particularly important. Timing of the injury, presence of a hematoma, loss of consciousness, and persistent vomiting are all very important things to document, whether you order the CT scan or not, he advises.

"I tell parents I am treating their child just as I would want my own child treated," says Meredith. If Meredith wants to encourage them to get the CT scan, he explains the risks of not finding out if there is a bleed present, while if he wants to dissuade parents from a CT scan he doesn't believe is warranted, he explains the risks of radiation and recommends observing the child instead.

If an EP sees very few pediatric patients a day, however, he or she will be "a lot less comfortable sending them home without a diagnostic test," says Meredith. "There are definitely more lab tests ordered than there need to be on most pediatric patients who are not treated at a pediatric facility."

Most children get a CBC and a basic metabolic panel, for example, says Meredith, when it's not clinically indicated. For instance, Meredith gives the example of a child who had a seizure at home and is getting back to his or her normal baseline, but has a CBC ordered at a community ED showing an elevated white blood cell count that is a result of the seizure.

"They can't send the patient home because of the concern about a possible infection. Now the physician doesn't know what to do, except transfer the patient to a higher level of care," Meredith says.

A child may come in with abdominal pain without a convincing story or examination indicating appendicitis because it's the first day of his or her symptoms, so the EP chooses not to do a CT scan. The next day, the patient comes back with appendicitis, and the family is angry that you didn't catch it the previous day. To avoid a lawsuit in a scenario like this, says Meredith, "that's where good discussions with the family about why follow up is so important come into play." ■

REFERENCE

1. Nigrovic LE, Schunk JE, Foerster, et al. The effect of observation on cranial computed tomography utilization for children after blunt head trauma. *Pediatrics* 2011: 127(6);1067-1073.

Sources

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Even Informal Consults on ED Patients Could Come Up in Suits

Document your reasoning

The "second-look EKG" is a good risk-management strategy, according to **Robert**

Broida, MD, FACEP, chief operating officer of Physicians Specialty Limited Risk Retention Group in Canton, OH. If you are the treating physician for any patient with chest pain being considered for discharge, it is a good practice to have another physician review and initial the EKG before discharge, he advises.

"Not only will this help prevent EKG misreads, but it also provides the opportunity to discuss the case with a colleague," he says.

Would this consultative approach increase the liability of the second physician, however? Broida acknowledges that it would, but adds that, "The 'two heads are better than one' approach decreases the total liability risk and promotes better patient outcomes."

If you have an unusual or puzzling case, it is good medicine to consult with another EP about the case, or to consult with other specialists such as a neurosurgeon, infectious disease specialist, neonatologist, or obstetrician, according to **Michael M. Wilson**, MD, JD, principal malpractice attorney at Michael M. Wilson & Associates in Washington, DC.

"An EP cannot know everything about every field of medicine, even though patients can walk in with problems that require the collaboration of specialists in several fields," he says. In fact, says Wilson, making the best possible decision in a collaborative manner "can demonstrate the best of medicine."

Robert B. Takla, MD, MBA, FACEP, chief of the Emergency Center at St. John Hospital and Medical Center in Detroit, MI, says he doesn't see any increased liability risks involving "curbside consults" with other EPs, and that, in fact, these can prevent potential lawsuits.

An informal consult can be potentially life-saving, says Takla, for an ED patient with an unusual presentation that a colleague has seen before. "An EP may have a heightened sense of awareness because they've been burnt on it in the past or know somebody who has," he explains.

Should You Document?

If you discuss your ED patient with a consultant, Wilson advises documenting the date and time of the consultation, who the consultant was, what the EP told the consultant, what the consultant told the EP, and the processing and follow-up of the consultant's recommendations.

"The consultation should always be documented, even if the EP rejects the consultant's recommendations," says Wilson.

If it's another EP Takla is consulting with, he doesn't include this information in the patient's chart. "I don't know of any specific cases where an EP has gotten into trouble because somebody intentionally dragged a colleague they consulted with into the situation by documenting his or her name in the chart," he adds.

The plaintiff's attorney is not likely to be aware of the "curbside consults" because they're not typically documented. "I don't ever write the names of EP colleagues that I run something by," says Takla. "The plaintiff's attorney would have a difficult time discovering this, and would almost never know that another EP was consulted."

If a specialist is nearby and Takla informally discusses a patient with him or her, however, he's more likely to document this because the specialist presumably has more expertise in a given area. "If the EP reviews the EKG with a practicing cardiologist, it's important to document that," says Takla. "That's very different from me walking over to my colleague and saying, 'What are your thoughts on this?'"

Advice Not Followed?

If an EP who is not involved in a case expresses an opinion to you, you have no legal obligation to follow it, says **Frank Peacock**, MD, vice chief of emergency medicine at The Cleveland (OH) Clinic Foundation. "ED doctors talk to each other all the time on shifts. They will say, 'Look at this rash for me,' or, 'Push on this guy's belly and see what you think.'"

Using an EP as a sounding board doesn't mean you have to follow his or her advice, "which might be flat out wrong," says Peacock.

However, if a consultant gives an opinion you disagree with, Peacock says you should document this because he or she is also documenting on the case. "A consultant usually knows a lot about their area of expertise, and not much about anything else," he adds.

If an ophthalmologist documents that the patient's eyeball looks fine but he thinks the patient's chest pain should be evaluated, says Peacock, don't let the statement stand unchallenged. Instead, document that, "The patient's pain is not consistent with anything that needs emergency evaluation," he says.

If the recommendations of a consultant are rejected, Wilson says that the reasons for this should be carefully documented. "Of course, if the consultant was correct, and the EP failed to follow the sound recommendations of the colleague

or specialist, merely documenting the decision will not protect the EP from exposure to liability," says Wilson.

However, if the decision-making process is sound and well-documented, even a decision that ultimately turns out to be incorrect may be defensible, he adds.

If an EP or consultant provides advice that is not followed, the plaintiff's attorney will normally be able to provide the jury with information about the consultation and the failure to follow the recommendation, whether or not the consult is documented, says Wilson.

"Every careful plaintiff's attorney will ask the EP about any discussions or consultations with other physicians in treating the patient, and then will depose the consultants that seem to have given important advice," says Wilson.

However, Wilson emphasizes that the most important aspect is the soundness of the decision-making process. "The EP may have had good reason to reject the consultant's recommendations at the time, even if that decision later on turned out to be wrong," he says.

Documentation as to the reasons for the rejection of the recommendations is critical, underscores Wilson. "If the recommendation is not followed because the EP got busy with another patient and forgot about the recommendation, that lapse could make the failure to follow the recommendation extremely difficult to defend," he says.

In this case, he says, the EP will be deposed and asked, "Why did you not follow the recommendation of Dr. Jones to check the potassium level before discharging the patient on furosemide who has come in with an irregular heartbeat?"

The EP's deposition testimony, such as, "I had an emergency patient come in immediately afterwards, and in the process of saving that patient, I forgot about Dr. Smith's recommendation and discharged the patient because we needed the bed," will, of course, be admissible. "It may lead to an inability to successfully defend the case," says Wilson. ■

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

HERE ARE THE STEPS YOU NEED TO TAKE TO EARN CREDIT FOR THIS ACTIVITY:

1. Read and study the activity, using the provided references for further research.

2. Log on to **www.cmecity.com** to take a post-test; tests can be taken after each issue or collectively at the end of the semester. *First-time users will have to register on the site using the 8-digit subscriber number printed on their mailing label, invoice, or renewal notice.*

3. Pass the online tests with a score of 100%; you will be allowed to answer the questions as many times as needed to achieve a score of 100%.

4. After successfully completing the last test of the semester, your browser will be automatically directed to the activity evaluation form, which you will submit online.

5. Once the evaluation is received, a credit letter will be sent to you. ■

CNE/CME QUESTIONS

1. Which is recommended to avoid lawsuits alleging a patient's cancer was caused by needless CT scans, according to **Sandra Schneider**, MD?
   A. Avoid mentioning specific risks of cancer if a CT scan is ordered.
   B. Discuss alternatives to a CT scan only if the patient and family express concern about cancer risk.
   C. Do not routinely ask patients to sign a consent form if a CT scan is ordered.
   D. Document the statement, "I have discussed with the patient that there is a small risk of cancer from getting a CT scan," in the patient's chart.

2. Which is true regarding prevention of EKG misreads, according to **Robert Broida**, MD, FACEP?
   A. If you are the treating physician for a chest pain patient being considered for discharge, having another EP review and initial the EKG before discharge is a good risk management practice.
   B. Having another emergency physician review and initial the EKG before discharging a chest pain patient does not reduce legal risks for either physician.
   C. Asking another EP to review a chest pain patient's EKG does not reduce misreads.
   D. Asking another EP to review a chest pain patient's EKG does not increase the liability of the second physician.

3. Which is recommended to reduce risks, in the event that an EP or consultant gives a recommendation on an ED patient, according to **Michael M. Wilson**, MD, JD?
   A. The EP should avoid documenting exactly what was said to the consultant.
   B. The consultation should not be documented if the EP rejects the consultant's recommendations.
   C. If the recommendations of a consultant are rejected, it is not advisable for the EP to document the reasons for this.
   D. If the decision-making process is sound and well documented, even a decision that ultimately turns out to be incorrect may be defensible.

4. Which is recommended to reduce liability risks involving ED patients requesting a diagnostic test that is not clinically indicated, according to **Ben Heavrin**, MD?
   A. The EP should avoid discussing specific risks of the diagnostic test being requested with the patient.
   B. The EP should document that he or she discussed with the patient that the risks of the diagnostic test outweigh the benefits of any information expected to be obtained from the test.
   C. It is not advisable for the EP to look up previous medical records or ask patients if they've had additional scans at other facilities.
   D. If a patient threatens to sue because a test wasn't ordered, this should not be documented by the EP.