ED Legal Letter™

The Essential Monthly Guide to Emergency Medicine Malpractice Prevention and Risk Management

From the publishers of *Emergency Medicine Reports* and *ED Management*

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November 2011
Vol. 22 • No. 11 • Pages 121-132

Current Liability Perspectives By Emergency Medicine Leaders

Crowding compounds risks

Overcrowding and emergency department (ED) boarding are the two top liability risks that **Douglas Brunette**, MD, assistant chief of emergency medicine for clinical affairs at Hennepin County Medical Center in Minnesota, sees for EDs currently.

"Long wait times for admission beds to become available stretch an already thin provider workforce, and lengthen the time to see a physician for the patients waiting at triage," says Brunette, adding that it is easy to miss the chest pain patient when there are 30 patients waiting to be triaged.

Geriatric ED patients "are an area that I see becoming more and more problematic," says **Mark S. Rosenberg**, DO, MBA, FACEP, FACOEP-D, chairman of the Department of Emergency Medicine, Geriatric Emergency Medicine, and Palliative Medicine at St. Joseph's Healthcare System in Paterson, NJ, adding that 38,000 of the ED's 135,000 annual visits are by geriatric patients.

Elder ED patients often present with vague complaints such as not feeling well, as well as have many comorbidities and decreased functional reserve, notes Rosenberg. "They frequently present with what seems like a minor problem that turns out to be catastrophic," he says. "All of this is compounded by the overcrowding and long wait times that many EDs are struggling with."

A 76-year-old patient with high blood pressure and diabetes may seem to have a minor complaint at first, but "may turn out to have an absolutely horrible complication with diseased intestines or bowel obstruction," says Rosenberg. "EDs are seeing this more often as the population ages, and more admissions are being held."

To improve care and reduce legal risks in this population, the hospital developed a geriatric ED. "Years ago, we decided that the best place to take care of kids is in a pediatric ED where staff are uniquely trained to understand normals and abnormals in kids," says Rosenberg. "We translated that into the geriatric population."

Additional training on geriatric patients was provided to all ED nurses and physicians, and the triage process was changed, with an EKG now done for

any elder patient who presents with any complaint between the jaw and the pelvis.

"We have made many changes that I would recommend for all hospitals, to improve the care they are giving to seniors," says Rosenberg. "Good care translates into less risks."

Due to a hospital-wide initiative, Rosenberg says that admitted ED patients aren't typically held for lengthy periods in the ED while waiting for inpatient beds to become available. "We don't hold patients for a long period of time like most hospitals are complaining about," he says. "Patients held in the ED frequently don't receive the same standard of care that they would have upstairs on the floors or [intensive care units]."

While some hospitals have taken the approach of moving patients from ED hallways to inpatient hallways, Rosenberg says he doesn't feel this reduces risks. "Our hospital disagrees with keeping patients in hallways. That is just moving the problem elsewhere, and we didn't think it was good care," he says. Instead, an electronic tracking board has cut down significantly on the ED's wait times since patients are being discharged earlier in the day.

Leslie S. Zun, MD, MBA, FACEP, FAAEM, chair of the Department of Emergency Medicine at Mount Sinai Hospital and Chicago Medical School in Chicago, IL, says he sees increasing legal risks due to psychiatric patients spending longer periods of time in the ED.

One scenario involves the psychiatric patient who wants to leave against medical advice (AMA). "They might want to leave right away because somebody else brought them in, either the police or their family, and they choose not to be there for a psychiatric evaluation," he says.

In this scenario, says Zun, it's necessary to assess whether the patient is competent to leave AMA. "They have to wait until you've had a chance to assess their competency, so you're going to be keeping them there with or without their permission," he adds.

Another area of risk involves the emergency physician's (EP's) assessment of whether the patient is at risk for harming him- or herself or others. "They may be competent to leave AMA, but they might want to kill themselves or somebody else, and we can't let that happen," says Zun. A patient may not have a cognitive deficit, but may want to kill someone because he is hearing voices and not considered competent, notes Zun, or may be a gang member who is competent but plans to harm someone.

"There are tools one can use to determine competency to consent for treatment, but EPs aren't usually comfortable with those kinds of tools and don't apply them very often," says Zun, adding that there are no formal practice guidelines from professional societies to assess an ED patient's ability to consent.

"What this unfortunately leads to is that the EP has to do their usual and customary assessment," says Zun. "EPs tend to do a much abbreviated mental status exam. They may just be asking the patient orientation questions, which are not sufficient to determine if they have the capacity to consent."

Zun says that the term "medically clear" could pose legal risks because it is often misunderstood. An appropriate evaluation of the patient is needed to determine if he or she has any medical problems

ED Legal Letter™, ISSN 1087-7347, is published monthly by AHC Media, 3525 Piedmont Road N.E., Bldg. 6, Suite 400, Atlanta, GA 30305. Periodicals Postage Paid at Atlanta, GA 30304 and at additional mailing offices.

POSTMASTER: Send address changes to ED Legal Letter, P.O. Box 105109, Atlanta, GA 30348.

Subscriber Information: Customer Service: (800) 688-2421. Customer Service E-Mail Address: customerservice@ahcmedia.com. Editorial E-Mail Address: leslie.hamlin@ahcmedia.com. World Wide Web: http://www.ahcmedia.com. Subscription Prices: United States: $499 per year. Add $17.95 for shipping & handling. Multiple Copies: Discounts are available for group subscriptions, multiple copies, site-licenses or electronic distribution. For pricing information, call Tria Kreutzer at 404-262-5482. Canada: $529 per year plus GST. Elsewhere: $529 per year. Back issues: $83. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue's date. GST Registration Number: R128870672.

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that are causing or exacerbating the psychiatric presentation, says Zun. "If they have some medical problem that's causing their psychiatric symptoms, then we should be treating their underlying illness. They may not need to go to psychiatry," he says.

The term "medically clear," however, is often misunderstood as indicating that the patient doesn't have any medical problems, says Zun. "What it means to me is that the patient may have medical problems but they have been stabilized. Maybe what we should say is they are 'medically stable.' Preferably, the EPs should write a detailed note about what they think is going on with the patient."

Regarding indications for involuntary admission, Zun says the biggest risk he sees is failing to hold an ED patient who later harms him- or herself or others.

"If the emergency physician, with good intent, held someone against their will, as far as I understand, the courts would support the physician's decision," he says. "If there is any question, you want to err on the side of keeping the patient."

If you decide involuntary assessment in the ED or admission is necessary, says Zun, "you really need to document as much as you can to explain why you made the decision to hold someone against their will. Anybody reading the chart should understand why you chose to do this."

Do EMRs Create Legal Risks?

Bruce Janiak, MD, professor of emergency medicine at Medical College of Georgia in Augusta, says he is very concerned about the legal risks posed by use of electronic medical records (EMRs) in EDs. "I don't know that there will be more suits, but I think there will be more suits that are lost, or can't be defended, or will be settled," he says, because the record can't support what the EP did.

"Plaintiff attorneys think this is the greatest thing since sliced bread, because almost every single ED record is subject to being easily ripped apart. Contradictions are just everywhere," says Janiak, adding that he reviewed two recent cases involving EMR documentation. "Both of the EPs are basically saying, 'I didn't mean what I said. The computer made me do it.'"

One case Janiak reviewed involved an EMR that asked the question, "Is this a penetrating eye injury," and the EP mistakenly answered the question with a mark slanted in the wrong direction to indicate that there was. It turned out that the patient actually *did* have the injury.

"There was no way to defend that. He had to bite the bullet, and the insurance company had to pay," says Janiak.

In a handwritten chart, says Janiak, the triage nurse's notes are up in front with the most important information the EP needs to know, such as, "Patient states chest pain for four hours." "That same phrase is in the EMR, but it's buried among 10 pages of information you don't need," he says. "Thrown into the middle of all that is something that is of value, but how do you find it? I've looked at EMR charts for 10 minutes and couldn't find the vital signs."

Janiak says that the result is a disjointed document that no layperson would be able to comprehend. "Juries are just now starting to see these, as attorneys blow them up on the big screens," he says. "I've had plaintiff attorneys tell me that it's hard for them to figure out what anybody did because they can't find it either." ■

Sources

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ED Patient May Share Blame for Bad Outcome, But Can You Prove It?

Document specifics about noncompliance

If an ED patient dies because she doesn't take antibiotics, as instructed by the emergency physician (EP), this doesn't mean that her family won't later sue for medical malpractice.

If a case such as this goes to trial, the EP's defense attorney can include a line in the jury charge stating that the plaintiff was "contributorily negligent," if you have shown evidence of this, says **Linda M. Stimmel**, JD, a partner at Wilson Elser Moskowitz Edelman & Dicker LLP in Dallas, TX.

"I've won several lawsuits because a jury understood that a patient was negligent," says Stimmel. One case involved a patient who died after not following instructions to return to the ED if he developed a fever, and the jury ruled in favor of the EP.

"You have to be careful about how you present the evidence, and it has to be done delicately," says Stimmel. "But you absolutely can use the patient's noncompliance as a defense in a medical malpractice lawsuit."

The patient's negligence may come out in depositions or expert reports during the development of the lawsuit, or it may become an issue at trial. Regardless, charting and documentation will become very important.

"Many times, I will talk to an ED nurse or physician who knew the patient would be non-compliant but they didn't chart it," Stimmel says.

If a patient's wife tells you, "My husband never takes his medications," or a patient leaves your ED saying, "I'm not sure I'm going to come back in for the blood test," this should be documented in quotes, advises Stimmel, instead of just charting the word "noncompliant," which won't mean much to you several years later.

"If you document these issues appropriately, then you automatically have evidence in the chart that the patient's actions, or inactions, may have contributed to the outcome," says Stimmel. "That will help you a lot."

If the patient's noncompliance comes up during the development of the lawsuit, says Stimmel, "it automatically weakens the case, and sometimes the case will go away. Ultimately, the jury's acceptance of the patient's negligence will very much depend on the facts of the case."

EP May Be Partially Liable

In some states, if the jury finds the patient is 70% responsible and the EP is 30% responsible, this means the EP is still liable for 30% of the verdict, says **Arthur R. Derse**, MD, JD, FACEP, professor of bioethics and emergency medicine at the Medical College of Wisconsin, whereas in other states, the EP is not held responsible at all if the patient is found to be 50% or more responsible.

Victoria L. Vance, JD, a health care attorney with Tucker, Ellis & West in Cleveland, OH, says that in some states, a patient's actions or inactions, which serve as a proximate cause of their own injury, may constitute a complete bar to recovery in a medical malpractice action.

In other states, says Vance, a jury will be asked to review and compare the misconduct of the patient against the allegedly negligent conduct of the defendant physician and assess their relative fault, thereby reducing the patient's recovery in proportion to their fault.

"For the defense to be viable, the defendant physician has the burden to prove that the patient's conduct fell below the standard to which he or she should conform for their own protection and safety," says Vance, and the patient's conduct must be a proximate cause of his or her own injuries. In addition, the patient's conduct must be contemporaneous with the physician's alleged malpractice, and not be a prior bad act, says Vance.

A related defense is available in some jurisdictions, adds Vance, involving the failure of the patient to mitigate his or her damages. This defense would involve a scenario in which a patient's failure to return to the hospital or doctor, as instructed, does not cause the injury but only makes it worse.

Procedurally, says Vance, the defense of "contributory negligence" is raised in the initial pleadings filed by the physician's counsel in answer to the complaint. As the case is investigated and prepared for trial, the issue of the patient's conduct will be explored during depositions, through the medical record review, and by asking the experts to render an opinion on the reasonableness of the patient's conduct, she says.

"Rarely will a judge dismiss a case solely on a

contributory negligence defense," says Vance. "But if the facts supporting the defense are compelling, a fair-minded and practical plaintiffs' attorney may decline to take the case, or may voluntarily dismiss the case."

Alternatively, says Vance, some plaintiffs' lawyers will be forced to reevaluate their case and may look to settle it for a fraction of the value the plaintiff originally had in mind for the case.

Is Patient Sympathetic?

A patient's ED visit may have resulted from high-risk behavior, but that doesn't mean that he or she is legally negligent for a bad outcome resulting from poor ED care, says Derse.

"If someone is seriously injured while roller skating on a freeway, and something the EP does falls below the standard of care and a bad outcome results, it may seem that the person contributed to their own injury because of their prior actions," says Derse. However, EPs "take our patients as they come," says Derse. "Their prior actions don't mean they have assumed any risk of being treated in some way poorly by us."

The fact that the patient was injured as a result of substance abuse, for instance, doesn't relieve the EP of the duty to adhere to the standard of care, he explains. "Interestingly, the fact that a plaintiff engages in unhealthy or risky behavior, even if he or she smokes, drinks, or uses drugs, does not seem to be as important a factor as whether he or she is a sympathetic person," says Derse.

The fact that a patient is morbidly obese with multiple medical problems won't necessarily make a jury less sympathetic to him or her, says Derse, but the same might not be true if a patient is abusive, obstinate, and disrespectful while in the ED.

"If a patient is combative, it's possible that injuries that the patient suffered might not be identified by the EP, and there may be some omission made," says Derse. The EP's defense could be that the patient's combativeness contributed to a resulting bad outcome, says Derse, but "the reality is that we have to deal with difficult patients all the time."

If the patient countered by stating that his behavior was due to a head injury and the jury believed this to be true, then the EP's defense of contributory negligence would be difficult to maintain, says Derse. "However, if a patient won't allow the EP to examine him, it may be used as evidence that the patient contributed to the inability to make a diagnosis," he adds.

Untruthful History

Patients can also be contributorily negligent if they're not honest in providing their history to the EP, but this may come down to a credibility contest.

"If you have a detailed, accurate history of what the patient told you, the jury is going to believe that you wouldn't have missed something," says Stimmel. "But if you have a thin, vague history without many details, the jury will not believe that you asked the right questions."

A patient may lie to the EP for the purpose of obtaining narcotics, for instance, "but it turns out that they have something else going on that you missed entirely," says Derse. If a young cocaine user tells an EP that his chest pain is from heavy lifting and vehemently denies any substance abuse, for instance, then dies of a myocardial infarction, this could be used to make a claim that the patient was contributorily negligent because he withheld information.

"That evidence could be used by the defense to say that the EP could not make an accurate evaluation because of the intentional misrepresentation on the part of the patient," says Derse. The defense would argue that had the EP known about the cocaine use, a different work-up and course of treatment would have been pursued.

It then becomes a question of whether the jury believes that patient really did report the cocaine use to the EP, and the EP failed to document it, or if the EP is telling the truth. "It now becomes simply a matter of credibility," says Derse. To reduce risks, he says to "chart the important negatives. Document 'this didn't happen,' or 'the patient didn't have this.'"

After Discharge

A case can be made for contributory negligence if an ED patient is noncompliant with discharge instructions, says Derse, such as a patient with an ankle injury who plays in a touch football game and ends up with a fracture.

"If the patient said, 'I wouldn't have had this fracture if the EP hadn't missed the extent of this particular injury,' says Derse, the EP could counter that the patient specifically went against his recommendations to elevate his ankle, apply ice, and rest.

"The problem with that is that it generally has to be a recommendation that a reasonable person would understand that they should not do it," says Derse. For instance, a contributory negligence defense is more likely to be accepted by a jury if the patient with an ankle fracture plays touch football right after leaving the ED, than if the patient simply went to work the following day instead of adhering to strict bed rest.

However, Derse says that juries will generally give the benefit of the doubt to the plaintiff because the EP has superior medical knowledge, and will also be sympathetic that patients have to get on with their lives and do things.

"Unless the patient was clearly told something in very specific terms, the jury will feel that patients don't have the medical knowledge to figure out all of the nuances," says Derse. Many jurors are not completely compliant patients themselves, notes Derse, and, therefore, won't expect the plaintiff to have followed every single instruction to the letter.

Juries also know that doctors don't always communicate well, he adds, so if the patient states, "The doctor may have told me that, but I didn't understand it and didn't ask about it," juries may sympathize with this.

"The fact that you have a checklist of 50 things doesn't mean a reasonable juror will agree that it is something the patient should have known," Derse says. ■

Sources

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Is a Joint Defense Approach in Best Interest of a Sued EP?

Defendable case may be settled

When a medical malpractice lawsuit is filed, the emergency physician (EP) and the hospital are often represented by the same defense counsel, but there are times when this is not in the EP's best interest, according to **Robert B. Takla**, MD, MBA, FACEP, chief of the Emergency Center at St. John Hospital and Medical Center in Detroit, MI.

"A lot of it depends on how much autonomy is given to the EP, whether they have the right to say, 'I don't want to settle,'" says Takla. If the same insurance company happens to cover both the hospital and the EP, one defense attorney typically represents both parties, he notes.

"But some EPs are a little bit wary of having a joint defense," he says. "They want to have the ability to say, 'No, I don't want to settle this case. I want it to go to court.'"

That decision isn't always up to the EP, adds Takla, as the hospital risk manager might decide to settle a defendable case for $25,000 rather than spend $30,000 in legal fees and risk a bad judgment.

The insurance company would rather pay one attorney to represent both the EP and the hospital, says Takla, but, at times, it's in the individual EP's best interest to be represented by separate counsel. "Sometimes, if the EP doesn't like the direction that the hospital attorney has in mind, he or she will get their own counsel," he says.

An EP may be against settling a case because there was no deviation of the standard of care, for instance. In one case reviewed by Takla, an EP discharged a patient after a Doppler ultrasound looking for testicular ischemia showed good blood flow, but the patient sued the EP after returning days later with a necrotic testicle. "The EP didn't do anything wrong whatsoever, and chose not to settle, but the jury ended up giving a verdict against him," says Takla.

It would have probably cost less money to settle the case, Takla acknowledges, but in this type of scenario, the EP may not want to admit to wrongdoing. "The business decision may be to settle the case, but the EP will say, 'Why should my premiums have to go up? Why should I have a scar on

my record?'" he says. "The EP may rather defend it and, ultimately, be proven not guilty."

Joseph P. McMenamin, MD, JD, FCLM, a partner at Richmond, VA-based McGuireWoods and a former practicing emergency physician, says that the ability of physicians to control whether a case is settled "is less than it was a generation ago."

Years ago, he says, many insurance policies included a Consent to Settle clause stating that they would settle a case only if the insured physician consented to doing so and, otherwise, the case would be defended.

"As the malpractice problem got worse, fewer insurers are willing to provide those clauses today," says McMenamin. Those that do provide a "hammer" clause, which is a provision that states if the case could have been settled for a certain amount, but it goes to trial because the physician exercises his or her rights under the Consent to Settle clause, and it ends up costing more as a result, the physician is responsible for the difference. "How many physicians can afford to take that kind of a risk?" asks McMenamin.

McMenamin says a joint defense is desirable in most cases — not just because this approach can save money, but also because defendants are less likely to criticize one another. "The best thing that can happen for a plaintiff in most malpractice cases is for defendant A to criticize defendant B, for a number of reasons," he says.

First, medical professionals are more sophisticated and knowledgeable about the facts of what occurred. "They are going to be able to mount more pointed, accurate criticisms than laypeople, including very intelligent lawyers," McMenamin says. "The attack that you get from your co-defendant may be more telling and more damaging than the one from the plaintiff."

Also, says McMenamin, human nature being what it is, once defendant A attacks defendant B, defendant B is going to be inclined to counterattack. "The plaintiff gets to sit back and be a bit of a spectator, watching the gladiators go at it," he says. "The jury is listening to doctor A say that doctor B goofed. They're going to bet that somewhere along the line, somebody goofed. That conclusion has to benefit the plaintiff."

For this reason, defendants generally avoid criticizing each other, says McMenamin, adding that there are circumstances where it's virtually impossible to do so. Years ago, McMenamin defended an ear, nose, and throat (ENT) physician who did a radical neck section based on the pathologist's interpretation of a frozen section, incorrectly reporting a malignancy. Days later, the permanent report showed the disease was benign, and the patient sued.

The pathologist and the ENT physician were represented by separate defense counsel. "We both knew there was great risk in attacking each other in court but, to my great dismay, the pathologist hired an ENT to opine on the quality of care that my guy offered," says McMenamin. "I was forced — and this is the only time in my career that I've done this, to hire a pathologist to criticize what my codefendant had done."

During recess, the judge asked counsel to come into chambers, and convinced both sides to settle the case. "This gives a sense of how things can go rapidly downhill if you get into the business of pointing figures at your codefendant," says McMenamin.

Criticism Not Necessary

Under certain circumstances, says McMenamin, the hospital and EP have interests that are not just separate, but different, and separate counsel is appropriate. "The fact that you have separate counsel, however, doesn't have to mean that you are criticizing each other," he says.

The deterioration of an unstable patient in a busy ED may go unnoticed by ED nurses who are caring for other patients, so the EP isn't notified in a timely manner. In this case, says McMenamin, the EP might argue that there are five nurses and only one physician, and that she depends on the nurses to be her eyes and ears. The nurses would then counter that they have an ED full of patients and a waiting room filled with still more, and that the EP should have paid more attention to the patient's condition.

Instead, the EP could simply say that he or she complied with the standard of care and acted on the information available to him or her, and take no position on the behavior of the nurses since he or she is not an expert on nursing care. Likewise, the ED nurses could say that they complied with the standard of care and take no position on how well the doctor performed.

"That way, the plaintiff has to do battle with the nurses on the one hand and the doctor on the other. Defendants can avoid knocking heads with each other in court," says McMenamin.

Typically, even where there exists some potential for adversity among defendants, defense counsel will look for ways to avoid engaging in that

type of fight, says McMenamin.

"If there just simply is no way around it, you may have to go after the other guy, and it's every man for himself," he says. "But that's really an unhappy choice to have to make. Fortunately, most of the time, it is not necessary to do that — and most of the time, you are better off if you don't."

EP May Want to Try Case

In some cases, the hospital may choose to settle the case and leave the EP to defend the case on his own. "That may not necessarily be a bad thing for the doctor," says McMenamin. "Now that the interests of other hospital personnel are not at risk, whoever the other folks in the case may be, the reluctance to go criticizing your former co-defendant disappears." It then becomes a perfectly viable option, says McMenamin, to say "It's the empty chair that's responsible, not I."

In addition, depending on state law, it's possible that the EP could get credit for the money paid by the hospital in the event the case is lost. "If the case is worth $500,000, and the hospital, to buy peace and not take the risk of a runaway verdict, pays $250,000, and the jury finds for the plaintiff $500,000, the court may say, 'I'm going to hit the doctor for the other $250,000, but not for the full $500,000,'" says McMenamin.

If the EP settles the case, his or her name is reported to the National Practitioner Data Bank, notes McMenamin, just as it would be if a case was lost at trial. "So that is another incentive for the EP to try the case," he says. "Unfortunately, your reputation may be blemished, even if you win, depending on how much attention people pay to the whole situation." ■

Sources

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Tempted to Blame Colleague? It May Have Unintended Effect

Liability increases for all concerned

When **Robert B. Takla**, MD, MBA, FACEP, chief of the Emergency Center at St. John Hospital and Medical Center in Detroit, MI, was named in a lawsuit early in his career, he was certain he hadn't breached the standard of care, though the same may not have been true regarding one of his emergency physician (EP) colleagues.

Five minutes before Takla's shift ended, a 67-year-old patient came in with a fever, so to move things along, Takla ordered a complete blood count, urinalysis, and chest X-ray, and documented this in the chart.

"That was the extent of my involvement with the patient," he says. The patient ultimately died of septic shock, and the only EP named in the subsequent lawsuit was Takla, not the EP who actually cared for the patient.

"I was mortified and angry, as I knew I had done nothing wrong. If there was anybody that the plaintiff's attorney should have been going after, it was a different EP," says Takla. "The defense said, 'Just trust me, you don't want to rat out your colleague. Let this run its course.'"

The case was settled for a nominal amount, and the second EP was never named in the case. Takla was instructed not to volunteer the information that he signed the case out to his colleague, and the plaintiff was never able to identify the other EP.

The more information that the plaintiff's attorney has, the more opportunity there is to prove there was negligence and deviation from the standard of care, warns Takla. "The less information there is available to them, the more difficult their job becomes," he says.

Getting two EPs involved in a case to point fingers at one another can only benefit the plaintiff, says Takla, because both are admitting that something went wrong. "The hospital is ultimately the deep pocket, but when you have the wide receiver pointing at the quarterback and vice versa, somebody is going to say, 'You guys messed up.'" he says. "The plaintiff doesn't care who pays."

At first glance, "finger pointing" may seem like a reasonable strategy, says **Ben Heavrin**, MD, assistant professor of emergency medicine at Vanderbilt University Medical Center in Nashville, TN, as shifting the blame onto another party may soften the perception that the accused was negligent, but it can quickly backfire.

"Finger pointing may make the accused appear overly defensive to a judge, attorney, or jury," says Heavrin. "This perception, in turn, could make the suggestion of provider negligence more plausible in their eyes." Finger pointing may result in additional unexpected testimony, as well, says Heavrin, and which may not be in a defendant's best interest.

"Finger pointing helps the plaintiff meet his burden of proving malpractice. It is the legal equivalent of shooting a ball into the opponent's basket," says **Victoria L. Vance**, JD, a health care attorney with Tucker, Ellis & West in Cleveland, OH.

Minimize Differences

Finger pointing happens when an individual defendant puts his or her self-interest ahead of the defense as a whole, explains Vance. "From a defense perspective, the preferred approach is that all the defendants 'fly in formation,' and mount a unified defense, making the plaintiff prove his case against each and every defendant," she says. Establishing that one defendant has committed malpractice is a tremendous burden, notes Vance, and proving that multiple defendants each breached the standard of care is "exponentially more difficult."

In some cases, it may become clear that the liability of some defendants may be greater than others. In that situation, the defendants are best served by focusing on defending their own conduct without being overtly critical of their co-defendants, Vance says.

"In situations where the liability profile among the defendants is disparate, and there are no signs of finger pointing, the plaintiffs' attorney will often concede that not all defendants are culpable, and non-liable defendants will be dismissed from the case," says Vance.

There are some situations where a fair and effective defense requires the defendant to be unapologetic about his or her role in the patient's care, however, and testify to facts that are unflattering to a co-defendant, adds Vance.

For instance, an EP may have given an order that was not followed, a nurse may have failed to properly monitor a patient and notify the EP of a significant change in his or her condition, or an ancillary service provider may have failed to notify the EP of a significant diagnostic result in a timely fashion.

"But even if the facts reveal separate liability exposures, very often the defendants can still find unanimity on issues of causation or damages," says Vance. "Again, the defendants, as a whole, benefit from such efforts to minimize their differences and focus on unifying themes."

Not in Patient's Chart

Ann Robinson, MSN, RN, CEN, LNC, principle of Robinson Consulting, a Cambridge, MD-based legal nurse consulting company, says that some situations are "almost impossible to avoid finger pointing, from a nursing perspective," such as an EP failing to listen to the nurse's report of a deteriorating patient, who finally goes into arrest.

"The nurse may have documented in the chart that the physician was made aware of the situation, and many minutes have gone by," she says. "If the timeline is examined retrospectively, it is clear that the nurse did everything possible to try to stave off this disaster."

The plaintiff's attorney would likely exploit this as a weak point in the defense, says Robinson, adding that it's a mistake for ED nurses to chart statements such as "the physician ignored what I told him."

She says that a better approach is to have a conversation with the EP or go up the chain of command so the conflict can be resolved immediately. If the ED nurse documents every attempt made to admit a patient he or she feels isn't ready for discharge, and the EP insists on discharging the patient anyway, the nurse should simply document the discussion that occurred, says Robinson. "That generally covers any potential liability that the ED nurse has, as far as their scope of practice, to be an advocate for the patient," she says.

Robinson reviewed a chart that stated, "Dr. advised, Dr. did not listen." "Try to keep in mind that what you are documenting will be read by other people, and will potentially be discovered during litigation," she says. "Ask yourself, are you writing a story as to what happened, or are you just airing grievances?"

If an ED nurse feels that the EP is mak-

ing a mistake that could harm a patient, says Robinson, he or she has many avenues to utilize, including risk management, the ED medical director, physician quality assurance, and corporate compliance. "There are certainly ways to deal with that, but not in the patient chart," says Robinson. "The dispute is not relevant to that patient's care."

Provide No Opinions

If an EP says that the nursing staff was negligent, or an ED nurse says that an EP was negligent, says **Linda M. Stimmel**, JD, a partner at Wilson Elser Moskowitz Edelman & Dicker LLP in Dallas, TX, this could lead to such questions during a deposition as, "Have you complained about this before," or "If you knew this other health care provider was not doing a good job, did you do anything about it?"

"Plaintiff's attorneys love that, because they don't have to do any work. They just sit back and let the defendants criticize each other," says Stimmel. "The plaintiffs look like good guys because they are not saying too many negative things, and we damage ourselves. All of a sudden, everybody looks negligent."

If something was missed because a radiologist misread a film, an EP does have to point out that he or she depended on a radiologist. "However, when you chart in that situation, I would suggest you be very careful in the wording," says Stimmel. "Be very fact-specific, and provide no opinions."

Instead of charting "the radiologist missed a mass" or "the radiologist misread the film," as one EP did in a chart reviewed by Stimmel, the EP should chart, "Received the radiology report on 5/10 from Doctor A, which noted no mass. Patient returned one week later, second film noted mass." This way, you have charted defensively to protect yourself, without providing an opinion.

"The radiologist is going to be less angry with you," says Stimmel, adding that the radiologist may have a reasonable explanation why a particular mass could not be observed on a particular film.

Likewise, says Stimmel, if an ED nurse doesn't think an EP is responding appropriately, he or she should chart in quotes both what he or she told the EP and the EP's response. Sometimes, the ED nurse may chart a vague statement like, "I conveyed a status update to Dr. Smith, and he doesn't feel the patient needs a further exam."

In this case, says Stimmel, "Many times, the EP will say, 'The nurse didn't tell me all of the information. If I had that information, I would have made a different decision.'"

Years later, in the middle of a lawsuit, says Stimmel, no one will be able to swear exactly the information they conveyed to another health care provider. "Additionally, EDs have been dismissed from lawsuits when there was complete, detailed, accurate charting," she says. "I've seen EDs remain in a lawsuit through trial when there was finger pointing in the chart." ■

Sources

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United States Postal Service

Statement of Ownership, Management, and Circulation

1. Publication Title	2. Publication Number	3. Filing Date
ED Legal Letter	1 0 8 7 – 7 3 4 7	10/1/11
4. Issue Frequency	5. Number of Issues Published Annually	6. Annual Subscription Price
Monthly	12	$499.00

7. Complete Mailing Address of Known Office of Publication *(Not printer) (Street, city, county, state, and ZIP+4)*
3525 Piedmont Road, Bldg. 6, Ste. 400, Atlanta, Fulton County, GA 30305
Contact Person: Robin Saiet
Telephone: 404-262-5489

8. Complete Mailing Address of Headquarters or General Business Office of Publisher *(Not printer)*
3525 Piedmont Road, Bldg. 6, Ste. 400, Atlanta, GA 30305

9. Full Names and Complete Mailing Addresses of Publisher, Editor, and Managing Editor *(Do not leave blank)*

Publisher *(Name and complete mailing address)*
James Stilf, President and CEO
AHC Media LLC, 3525 Piedmont Road, Bldg. 6, Ste. 400, Atlanta, GA 30305

Editor *(Name and complete mailing address)*
Shelly Mark, same as above

Managing Editor *(Name and complete mailing address)*
Leslie Hamlin, same as above

10. Owner *(Do not leave blank. If the publication is owned by a corporation, give the name and address of the corporation immediately followed by the names and addresses of all stockholders owning or holding 1 percent or more of the total amount of stock. If not owned by a corporation, give the names and addresses of the individual owners. If owned by a partnership or other unincorporated firm, give its name and address as well as those of each individual owner. If the publication is published by a nonprofit organization, give its name and address.)*

Full Name	Complete Mailing Address
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GSC, LLC	500 Campus Drive, Florham Park, NJ 07932
Natixis	9 West 57th Street, 35th Floor, New York, NY 10019
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11. Known Bondholders, Mortgagees, and Other Security Holders Owning or Holding 1 Percent or More of Total Amount of Bonds, Mortgages, or Other Securities. If none, check box → ☐ None

Full Name	Complete Mailing Address
Thompson Publishing Group Inc.	805 15th Street, NW, 3rd Floor, Washington, D.C. 20005

12. Tax Status *(For completion by nonprofit organizations authorized to mail at nonprofit rates) (Check one)*
The purpose, function, and nonprofit status of this organization and the exempt status for federal income tax purposes:
☑ Has Not Changed During Preceding 12 Months
☐ Has Changed During Preceding 12 Months *(Publisher must submit explanation of change with this statement)*

PS Form **3526,** October 1999 *(See Instructions on Reverse)*

13. Publication Title: ED Legal Letter			14. Issue Date for Circulation Data Below: September 2011	
15.	Extent and Nature of Circulation		Average No. Copies Each Issue During Preceding 12 Months	No. Copies of Single Issue Published Nearest to Filing Date
a.	Total Number of Copies *(Net press run)*		362	354
b. Paid and/or Requested Circulation	(1)	Paid/Requested Outside-County Mail Subscriptions Stated on Form 3541. *(Include advertiser's proof and exchange copies)*	153	167
	(2)	Paid In-County Subscriptions Stated on Form 3541 *(Include advertiser's proof and exchange copies)*	0	0
	(3)	Sales Through Dealers and Carriers, Street Vendors, Counter Sales, and Other Non-USPS Paid Distribution	16	34
	(4)	Other Classes Mailed Through the USPS	39	13
c.	Total Paid and/or Requested Circulation *[Sum of 15b. (1), (2),(3),and (4)]*		208	214
d. Free Distribution by Mail *(Samples, complimentary, and other free)*	(1)	Outside-County as Stated on Form 3541	19	20
	(2)	In-County as Stated on Form 3541	0	0
	(3)	Other Classes Mailed Through the USPS	0	0
e.	Free Distribution Outside the Mail *(Carriers or other means)*		20	20
f.	Total Free Distribution *(Sum of 15d. and 15e.)*		39	40
g.	Total Distribution *(Sum of 15c. and 15f)*		247	254
h.	Copies not Distributed		115	100
i.	Total *(Sum of 15g. and h.)*		362	354
j.	Percent Paid and/or Requested Circulation *(15c. divided by 15g. times 100)*		84%	84%

16. Publication of Statement of Ownership
☑ Publication required. Will be printed in the November 2011 issue of this publication. ☐ Publication not required.

17. Signature and Title of Editor, Publisher, Business Manager, or Owner — Date: 09/12/11

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CNE/CME QUESTIONS

1. Which is true regarding joint defense of an emergency physician and the hospital, according to **Joseph P. McMenamin**, MD, JD, FCLM?
   A. A joint defense is not desirable in most cases, because it avoids the scenario of defendants criticizing one another.
   B. If the hospital and EP have separate counsel, there is no way for the defendants to avoid criticizing one another.
   C. If the hospital chooses to settle the case and leaves the EP to defend the case on his or her own, this is never in the EP's best interest.
   D. If the hospital chooses to settle the case and leaves the EP to defend the case on his or her own, it's possible that the EP could get credit for the money paid by the hospital in the event the case is lost, depending on state law.

2. Which must be true for a defense of contributory negligence to be viable, according to **Victoria L. Vance**, JD?
   A. The defendant physician has the burden to prove that the patient's conduct fell below the standard to which he or she should conform for their own protection and safety.
   B. The defendant must prove that patient's conduct was a proximate cause of his or her own injuries.
   C. The patient's conduct must be contemporaneous with the physician's alleged malpractice, and not be a prior bad act.
   D. All of the above.

3. Which is true regarding an EP's claim that a patient was contributorily negligent for a bad outcome, according to **Linda M. Stimmel**, JD?
   A. EPs should document a patient's exact words in quotations if he or she makes statements indicating a likelihood of non-compliance.
   B. Charting the word "noncompliant" is sufficient, as opposed to detailed information on the nature of the patient's non-compliance.
   C. If a patient's ED visit was a result of engaging in high-risk behavior, this means that he or she is legally partially negligent for a bad outcome even if an EP failed to meet the standard of care.
   D. If a patient won't allow the EP to examine him or her, this cannot be used as evidence that the patient contributed to the inability to make a diagnosis.