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Plaintiffs Strive to Twist EMTALA Into a Federal Malpractice Act?

By Robert A. Bitterman, MD, JD, FACEP
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Plaintiff attorneys continue efforts to turn ordinary "failure to diagnose" malpractice claims into claims for "failure to provide an appropriate medical screening exam" under federal law, the Emergency Medical Treatment and Labor Act – EMTALA.

The Case of Macamaux v. Day Kimball Hospital[1]

In *Macamaux*, the Connecticut district court had to decide "whether this was a case of misdiagnosis based upon an appropriate screening examination or a case of failure to provide an appropriate screening examination" under EMTALA.[1]

Facts

Mr. Macamaux presented to the Day Kimball Hospital emergency department (ED) via EMS after a motor vehicle accident (MVA). He arrived in a cervical collar on a back board due to a complaint of neck and back pain. The triage nurse assessed him and listed complaints of neck pain, back pain, and pain between the shoulders. The emergency physician documented a chief complaint of "upper back pain" and did not document the presence or absence of neck pain. The physician later testified that the patient never complained of neck pain, but the physician did order trauma cervical spine X-rays with a chest X-ray (CXR).[1]

There was no radiologist in the hospital (it was just after 5 p.m. on a Monday) so hospital policy called for the emergency physician to initially read the X-rays and a radiologist to review the X-rays "subsequently."[1] After reviewing the images, the emergency physician reassessed Mr. Macamaux and determined that he had scapular pain, but no neck pain or tenderness (which was not documented in the record). However, he then ordered a repeat CXR and repeat lateral cervical spine film, allegedly because of the poor quality of the initial set of X-rays, along with an X-ray of the left scapula.[1]

The emergency physician interpreted the second set of X-rays to be negative and discharged the patient "Home with son — stable" on a diagnosis of "MVA — back strain."[1]

The next day, the hospital's radiologist reported that the C-7 vertebral body was, due to difficulty penetrating the shoulders, "not well seen" on the first X-ray and "is not included" on the second X-ray. The radiologist recommended that the patient follow-up with his physician, and these findings were reported to the ED. However, the radiologist's concern, for unknown reasons, was not communicated in a timely manner to Mr. Macamaux. The hospital did mail him a letter 5 days after his visit to the ED, but 2 days before it was sent, due to neck pain, arm pain, and difficulty breathing, he presented to the ED of a Rhode Island hospital where a CT scan revealed multiple cervical spine fractures and significant dislocation at the level of C7–T1.[1]

Mr. Macamaux's end result post surgery was not favorable, so he sued the emergency physician for negligence and sued the hospital pursuant to EMTALA for "failure to provide an appropriate medical screening exam," and for "failure to stabilize" his fractures and dislocation.[1]

The Court's Opinion on the "Failure to Screen Claim"

When a person comes to the ED requesting examination or treatment, a hospital is required by EMTALA to:

"*provide for an appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition . . . exists.*"[2]

The term, "appropriate medical screening examination," is not defined in the statute.[3] However, the courts have consistently held that this screening requirement is not a substitute for state law on medical malpractice[4] and was "not intended to guarantee proper diagnosis or to provide a federal remedy for misdiagnosis or medical negligence."[5]

Instead, EMTALA requires hospitals to provide uniform or non-discriminatory screening examinations, consistent with their own policies and based on the hospital's available resources and capabilities.[6,7] Consequently, the courts allow EMTALA "failure to screen claims" when a hospital does not follow its own standard policies and procedures, best summed up by the judge in *Gatewood v. Washington Health Care Corporation,* "any departure from standard screening procedures constitutes inappropriate screening in violation of the EMTALA."[8]

Plaintiff attorneys have latched onto these court declarations in an effort to file EMTALA claims for "failure to provide an appropriate medical screening examination" instead of suing providers under ordinary state malpractice law. They are highly motivated to do so for a host of reasons: sue hospitals, not physicians; get at the hospital's "deep pocket"; end run state tort reform on such things as expert witness requirements, affidavits of merit, and statutes of limitation; gain access to peer review documents (the federal rules of evidence do not recognize state peer review protections); and the big prize — attempt to circumvent state damages caps on non-economic damages.

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In California, a federal court recently held that the state's famed MICRA, it's malpractice reform and damages cap law, does not apply to federal "failure to screen claims" under EMTALA, thus the state's $250,000 cap on non-economic damages is inapplicable.[9] The plaintiff lawyers in California are consequently scrambling to recast every ordinary "failure to diagnose" claim against EDs as a "failure to screen" claim so as to avoid the state cap.

The effort to recast malpractice claims into federal EMTALA claims is so pervasive in Puerto Rico that even judges comment on the practice in their formal written opinions.[10] The reason is straightforward: in Puerto Rico, there are no jury trials in civil malpractice cases, unless the claim is heard in federal court.[10]

In light of this background, Day Kimball Hospital asked the court to dismiss Mr. Macamaux's failure to screen claim under EMTALA, claiming that it followed its usual screening process in examining and treating Mr. Macamaux in its ED.[1]

The plaintiffs counter argued that Day Kimball had a "Diagnostic Services Manual Policy" regarding the images that must be taken when cervical spine trauma X-rays are ordered. The policy listed a number of steps that "must be performed" that included a requirement that the "C7-T1 junction must be clearly visualized."[11]

The policy also further stated that if these X-rays are ordered when a radiologist is not on duty, as was the case here, the images will be brought to the emergency physician to review and the "emergency physician will notify the technologist whether or not the patient needs any additional films." The court noted it was uncontested that none of the X-rays received and reviewed by the physician permitted him to see and evaluate the C7 vertebrae or the C7-T1 junction.[11]

Day Kimball argued that the imaging policy applied to the radiology department, not the ED, and that it provides instructions to the radiology technicians for producing the images, not to the interpretation by the emergency physicians. The court, however, said that Day Kimball cited no authority that EMTALA liability may be founded only on a failure to follow policies directed specifically at the ED.[1]

In fact, EMTALA expressly imposes a duty and a corresponding liability upon *hospitals*, not specifically upon *emergency departments*: "the hospital must provide an appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department. . ."[2] And radiology/cervical spine imaging is certainly an ancillary service routinely available to the ED, so the court had no problem ruling that the hospital could be liable for failing to provide an appropriate screening exam regardless of whether the failure was attributed directly to the ED or to an ancillary service, such as radiology, that was working in conjunction with the ED to screen patients.[1]

The court then poignantly stated in a footnote, "It bears noting that, under the circumstances of this case, it fell to the emergency department doctor to read the insufficient X-rays."[1]

Below are some thoughts/suggestions to deal with this issue:

- Radiologists should provide proper service to the 120 million patients seen in our nation's emergency departments every year to avoid the long-known frequency of adverse patient outcomes and subsequent litigation due to non-contemporaneous interpretations by radiologists;
- Every single imaging study done in an ED, 24/7 and 365 days per year, should be interpreted in real time, ***before the patient leaves the ED***, by an appropriately trained and skilled radiology specialist.
- Payment Ramifications: (1) The federal government should mandate it be done for Medicare/Medicaid patients and pay for absolutely nothing less;[12] (2) hospital boards and CEOs should require such in the contract with their radiology group, or for any radiology group that seeks to bid on the hospital's business; and (3) the hospital's primary insurance carrier or reinsurer should mandate the practice or refuse to cover the hospital and physicians for liability related to missed findings that occur as the result of not providing real-time contemporaneous interpretations. Sometimes, physicians must be forced to do the right thing for patients, and taking their money or voiding their liability coverage is probably the mechanism most likely to succeed.

In the end, the court held that the radiology policy could reflect Day Kimball's expectations for its ED screening practice, and that a jury could "reasonably infer that, if Day Kimball insists that an X-ray 'MUST' show the C7-T1 junction, this is because the standard screening procedure for cervical spine trauma involves consideration of such an image."[1]

Therefore, the court said that the policy prevented it from deciding, as a matter of law, whether "this is a case of misdiagnosis based upon an appropriate screening examination or a case of failure to provide an appropriate screening examination."[1]

Thus, the case will go to the jury for it to decide whether an appropriate EMTALA medical screening examination was done for Mr. Macamaux.

The Court's Opinion on the "Failure to Stabilize" Claim

The court easily dispatched the plaintiff's EMTALA failure to stabilize claim against the hospital.[1] It is settled law that the hospital must fist determine that the patient has an emergency medical condition (EMC) — have *"actual knowledge"* that an EMC exists.[13]

Here, it was clear that the emergency physician diagnosed contusions/strains — non-emergency conditions — and did not diagnose fractures/dislocations or any other injury that needed immediate stabilizing treatment. Nonetheless, the plaintiffs alleged that the hospital and physician were well aware of the potential severity of Mr. Macamaux's injuries and, if not, they "should have known." The court was steadfast, agreeing with accepted appellate law that suspicion of an EMC, the "potential" for an emergency condition, considering an emergency condition in the differential diagnosis, or even that the physician "should have known" the emergency condition existed are all insufficient for the EMTALA claim — they simply don't constitute "actual knowledge" that the emergency condition exists.[1]

The Case of Hale v. Northeastern Vermont Regional Hospital (NVRH)[14]

In *Hale v. NVRH,* a 35-year-old woman presented to the ED with neck pain radiating to her temples and back. She was diagnosed with torticollis and discharged. Three days later, she returned complaining of bad head pain, neck pain, and back pain and was examined by the same emergency physician, who, this time, did a head CT scan and a lumbar puncture (LP). The results were suspicious for a subarachnoid hemorrhage (SAH), so the patient was transferred to a tertiary center that diagnosed a cerebral artery aneurysm. During an attempted coiling procedure, the aneurysm ruptured, leaving Ms. Hale neurologically devastated.[14]

The patient's family sued, claiming the hospital failed to provide an "appropriate medical screening examination" on the initial ED visit by failing to perform the CT and LP at that time.

(For the sake of discussion, ignore whether the standard of care indicated that a CT or LP be done then, and whether the initial visit played any role in the causation of the patient's injuries — causation being a necessary element to prove a malpractice or EMTALA claim for damages — as the patient almost certainly would have had the coiling procedure irrespective of whether the leaking aneurysm was diagnosed three days sooner.)

The court in *Hale* agreed with the *Macamaux* court that negligence alone is insufficient to support a claim for inappropriate screening under EMTALA, but it, too, stated that "departure from standard screening procedures constitutes inappropriate screening in violation of EMTALA."[15] Twice previously, in 2003 and 2004, Ms. Hale had presented to the NVRH ED complaining of headache, neck, and back pain, and both times an LP was performed. Thus, the court concluded that "a jury could reasonably infer that NVRH's standard screening includes performing an LP when a patient presents with head pain."[14]

More incredulously still, the court pointed to the fact that the hospital didn't have a "written LP policy," and couldn't produce "any evidence explaining its LP policy," which could lead to the jury's "reasonable conclusion."[14] Couldn't this bizarre uninformed logic have been dispelled by the hospital producing a zillion ED headache cases that did NOT get an LP? (Yes, the hospital will get its chance at trial, but it shouldn't be a trial issue.) Does any hospital in the United States have a written policy on the use of a lumbar puncture in the performance of EMTALA-mandated medical screening examinations? Why can't courts grasp the fact that ***physician judgment*** is the determining factor on when an LP (or, for that matter, any other invasive or noninvasive diagnostic study) is indicated under the particular circumstances of each individual case? The very nature of human biology and the practice of medicine dictate that there can be no "standard policy" on performing "screening" LPs.

Additionally, the plaintiffs asserted that when Ms. Hale presented to the ED in 2003 and 2004, and the LP was done, she was covered by insurance, whereas in 2006, she was not insured. The court stated that this assertion further supported an inference of disparate treatment (seemingly ignoring the fact that when Ms. Hale returned three days later and *did* get the CT/LP, she was still uninsured).[14]

Based on these issues, the court concluded that there was a question of fact as to whether or not NVRH performed a screening examination that conformed to its standard screening procedures. Furthermore, exactly as the *Macamaux* court stated, this court opined, "the

question is whether this is a case of misdiagnosis based upon an appropriate screening examination or a case of failure to provide an appropriate screening examination under EMTALA."[14]

Final Comment

The real issue is whether the courts will respect the intent of Congress, which did not intend to supplant state law medical malpractice liability with a federal malpractice standard of care. EMTALA was designed solely to prevent the specific injury of patient "dumping," for which state law typically did not redress.[16] As federal appellate courts have stated, "the avowed purpose of EMTALA was not to guarantee that all patients are properly diagnosed, or even to ensure that they receive adequate care,"[17] but rather it was intended as "a federal law that provided a remedy for emergency care patients where state malpractice provisions fell short."[18]

Lessons Learned

- Define your hospital's "appropriate" medical screening policy in terms of the law (i.e., a non-discriminatory approach to evaluating patients' complaints) and do not define your screening policy and procedures in terms of the medical "standard of care."
- Specifically state in your medical screening policy that all diagnostic testing or consultation with on-call specialists is discretionary, based on the judgment of the examining physician, and that no tests whatsoever are included as part of the hospital's "standard medical screening policy."
- Review the policies and procedures of other hospital departments that routinely interact with the ED, such as radiology, to ensure that those departments don't burden or bury the ED with respect to EMTALA compliance and litigation.
- Blind triage, nursing, and emergency physicians to the patient's insurance status until *after* the MSE and initiation of stabilizing treatment — it voids the argument that certain diagnostic tests were not done because the patient was uninsured.
- Document your medical decision-making when you don't take actions, such as CT/LP, that would normally be "considered," or when you don't follow an expected pathway or "guidelines."
- Always read and address triage, nursing, and EMS notes *before* the patient is discharged.
- Document the presence or absence of an EMC on all ED patients, so that it will never be a "question of fact" for a jury as to whether the emergency physician had "actual knowledge" that an emergency condition existed. (Place two boxes at the bottom of every ED chart: EMC Identified or No EMC Identified.)
- Advocate for accountable "radiology reform," which serves patients, not doctors. ■

REFERENCES

1. *Macamaux v. Day Kimball Hospital*, Case No. 3:09-cv-164, 2011 WL 4352007, (D. Conn. Sept. 16, 2011).
2. 42 USC § 1395dd(a).
3. 42 USC § 1395dd.
4. Eg., *Hardy v. NYC Health & Hosp. Corp.*, 164 F3d 789 (2d Cir. 1999), and *Gatewood v. Washington HC Corp.*, 933 F2d 1037 (D.C. Cir. 1991).
5. *Macamaux v. Day Kimball Hospital*, quoting *Power v. Arlington Hosp. Ass'n*, 42 F3d 851 (4th Cir. 1994).
6. E.g., *Marshall v. East Carroll Parish Hosp.*, 134 F.3d 319, 323 (5th Cir. 1998). ("Most of the courts have defined 'appropriate medical screening examination' as a screening examination that the hospital would have offered to any other patient in a similar condition with similar symptoms.")
7. See also, *Brooks v. Maryland Gen. Hosp. Inc.*, 966 F.2d 708, 710-11 (4th Cir. 1993) (Under EMTALA, "the hospital must apply its standard of screening *uniformly* to all emergency room patients, regardless of whether they are insured or can pay." (emphasis in original).
8. *Gatewood v. Washington HC Corp.*, 933 F2d 1037 (D.C. Cir. 1991). See also, *Repp v. Anadarko Mun. Hosp.*, 43 F.3d 519 (10th Cir. 1994). ("A hospital violates EMTALA when it does not follow its own standard procedures.")
9. *Romar v. Fresno Comm. Hosp. et al.*, 2008 U.S. Dist. LEXIS 85080 (E.D.Cal. Oct. 10, 2008).
10. *Cruz-Vasquez v. Mennonite Gen. Hosp. Inc., et al.*, Case 3:08-cv-01236, (D. PR. Sept. 20, 2011).
11. *Macamaux v. Day Kimball Hospital*, citing the Day Kimball Policy No. DI: Trauma Procedure.
12. There exists presently a 'contemporaneous' interpretation requirement for payment of reading imaging studies in the CMS regulations, but CMS refuses to enforce it and instead counts the reading done a day or two after the ED visit as 'contemporaneous' enough to warrant payment. Emergency physicians should bill for interpretations they provide in real-time; unfortunately, the politics or power positioning in most hospitals is still such that, contractually, radiologists are allowed to bill and the emergency physicians prohibited from doing so.
13. See, e.g., *Toretti v. Main Line Hosps.*, Inc., 580 F.3d 168 (3d Cir. 2009) (noting stabilization claim requires the hospital "actually knew" of the emergency medical condition); *Bryant v. Adventist HS West*, 289 F.3d 1162 (9th Cir. 2002)

("A hospital has a duty to stabilize only those medical conditions that its staff detects."); and *Holcomb* v. *Monohan*, 30 F.3d 116 (11th Cir. 1994) ("To succeed on an EMTALA stabilization claim, a plaintiff must present evidence that . . . the hospital knew of the emergency medical condition.")

14. *Hale v. Northeastern Vt. Reg'l Hosp., Inc.*, No. 1:08-cv-82-jgm (D. Vt. Sept. 30, 2011).
15. *Hale v. NE Vt. Reg'l Hosp*, citing *Gatewood v. Washington HC Corp.*, 933 F2d 1037 (D.C. Cir. 1991).
16. *Reynolds v. Maine General Health*, 218 F.3d 78 (1st Cir. 2000).
17. *Baber v. Hosp. Corp. of America*, 977 F.2d 872, (4th Cir. 1992).
18. *Correa v. Hospital San Francisco*, 69 F.3d 1184, (1st Cir. 1995).

Should an ED Suit Be Quickly Settled — or Vigorously Defended?

Agreeing to settle a plaintiff's claim alleging ED malpractice may not sound like a good idea to the emergency physician (EP) named in the lawsuit, but, in fact, this course of action is often in everybody's best interest.

"In general, a reasonable settlement reduces risk, and would be preferable to a jury trial," says **Michael M. Wilson**, MD, JD, principal malpractice attorney at Michael M. Wilson & Associates in Washington, DC. "Nationally, approximately 80% of cases tried to a jury result in defense verdicts."

Typically, the EP has a limited amount of coverage, of $1 or $2 million, for example, says Wilson, so a large verdict for a catastrophic injury could force the EP into bankruptcy, causing the loss of most of the EP's accumulated assets.

"The hospital is typically self-insured, or has a relatively small insurance policy compared to the value of its assets," adds Wilson. "The hospital could lose its assets if it were to be found liable for a catastrophic injury."

Generally, a fair and reasonable settlement is in the best interest of all parties, says Wilson. "This is why most cases are settled," he says. "For example, in the U.S. District Court for the District of Maryland, fewer than 1% of personal injury cases proceed to trial."

Under some circumstances, the EP can be reported to the National Practitioner Databank, says Wilson. "However, this would have fewer ramifications than a large public verdict followed by a personal bankruptcy," he adds.

When to Settle?

ED lawsuits sometimes settle after all of the witness depositions and expert depositions have been taken, says **Robert D. Kreisman**, JD, a medical malpractice attorney with Kreisman Law Offices in Chicago, but it is often expedient and prudent to settle claims or cases *before* they reach that level.

"One of the principal reasons is the expense associated with discovery, the hiring of experts, and the risk that the outcome may not be favorable to the ED physician or hospital," says Kreisman, adding that each case is unique and must be carefully analyzed.

"Furthermore, the damages that are being claimed have to be understood," he says. Because of the expense associated with prosecuting medical negligence cases of any kind, he explains, the damages to the patient are usually very significant, as someone is either injured severely or is deceased.

A plaintiff's lawyer would recommend that a case be settled when he thinks that the client would be reasonably taken care of over his or her lifetime, says Wilson, assuming a catastrophic, disabling injury, and that the amount to be paid would be reasonable considering the strengths and weaknesses of the case.

"In some cases, problems with the plaintiff's case do not permit a settlement that would cover all of the plaintiff's future needs," says Wilson. "Under these circumstances, the goal would be to obtain the highest settlement possible."

In catastrophic injury cases, a Special Needs Trust may be set up that accepts the settlement proceeds, and pays it to the plaintiff under a plan approved by a judge.

The main advantage of the Special Needs Trust is that the plaintiff would remain eligible for Medicaid payments, says Wilson, with the settlement proceeds supplementing Medicaid.

"The Special Needs Trust makes settlements attractive to both plaintiffs and defendants," says Wilson. Plaintiffs would otherwise be viewed as ineligible for Medicaid, and would need a very large amount to cover all of their needs for the remainder of their lifetimes without Medicaid contributions, he explains.

"For defendants, the case can be settled for much less than a jury would award if the plaintiff were to win at trial," says Wilson. ■

Sources

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Is Plaintiff Willing to Drop EP Named in Suit?

Independent contractor status is issue

Under what circumstances might a plaintiff's team be willing to drop the emergency physician (EP) involved in a lawsuit and allow the hospital to settle with the patient?

In most jurisdictions, the patient's reliance on the appointment of a physician in the emergency department to take care of him or her would give rise to an apparent agency relationship between the EP and the hospital, explains **Robert D. Kreisman**, a medical malpractice attorney with Kreisman Law Offices in Chicago. This means that in most cases, a lawyer would name both the EP and the hospital as party defendants.

In reality, however, it's more likely that the EP is an independent contractor associated with an ED group, who is not an employee of the hospital. The hospital would raise that lack of agency relationship, and assert that it should not be held responsible for the acts of the independent contractor, explains Kreisman.

"Therefore, it is not a common setting where a plaintiff's attorney would be willing to drop the EP from a claim or case without proof of employment, but continue on against the hospital," he says.

In other words, unless it was shown that the EP was, in fact, an employee of the hospital, it is unlikely that he or she would be released from the claim or case, says Kreisman.

Nevertheless, Kreisman notes that there is Illinois case law that supports the proposition that a hospital may be liable to a patient injured where an EP is seen to have "apparent authority."

The test for apparent authority is satisfied if the patient reasonably relied upon a hospital to provide medical care, rather than upon a specific physician, he explains, noting that most, if not all, ED patients don't select their doctor.

"Consent forms may be useful, but are not determinative as to whether or not the patient relied on the assigned physician to find a hospital liable under the apparent authority theory," adds Kreisman.

More Sympathetic Defendants

"Frequently, the plaintiff's legal team will decide to drop the individual defendants — physicians and nurses — who are viewed as more sympathetic defendants than a corporate defendant," says **Michael M. Wilson**, MD, JD, principal malpractice attorney at Michael M. Wilson & Associates in Washington, DC. He says that these are some of the possible conditions of the agreement to dismiss the individual defendants:

- A stipulation that the hospital is the proper defendant;
- A stipulation that the individual defendants being dismissed were, at all times, relevant, acting within the scope of their employment with the hospital;
- A stipulation that the hospital is vicariously liable for any alleged negligent acts or omissions of the individual defendants;
- A stipulation that the dismissal of the individual defendants does not, in any way, affect the liability of the hospital with respect to the actions of the dismissed individual defendants;
- A stipulation that all statements and testimony of the dismissed individual defendants may be introduced into evidence as if they were an employee of the hospital;
- A stipulation that the dismissal will not provide the basis for any defense motions; and
- A stipulation that the dismissed defendants will be made available for depositions if requested by the plaintiff or the plaintiff's counsel, and that the dismissed defendants will appear and testify voluntarily without the necessity of a subpoena or other expenses to the plaintiff at the trial of this matter.

"Defendants frequently require confidentiality," says Wilson. "Plaintiffs are generally more concerned about making sure that their future financial needs are taken care of." ■

Claim Against EP? Upfront Approach Speeds Resolution

Whether a claim against an emergency physician (EP) is ultimately settled, defended, or dismissed, taking an upfront approach has resulted in quicker resolution of claims, reports **Ryan Domengeaux**, vice-president of enterprise risk management and internal counsel for Schumacher Group, an emergency medicine practice management company in Lafayette, LA.

"When it comes to managing claims, there is just no place for defensiveness or obstinacy," he says. "What should take place is honesty, objectivity, and intent to do the right thing."

After a very thorough review of the case is completed, when a claim is first received by Schumacher Group, the next step is to have a candid discussion with the plaintiff or family and their counsel, regardless of Schumacher Group's evaluation of the claim. Almost every claim received in the past five years has followed this process, with the goal of finding a way to expeditiously seek resolution of the claim to the benefit of all parties involved.

"If we didn't visit with the plaintiff or family and their counsel very early on in a case, it's not for lack of an effort or desire on our part," says Domengeaux. "We want to visit with them early on in the claim to talk candidly about how we see the care. If we see a problem with the care, we say so."

The most challenging claims to close are those in which one of the parties *isn't* forthcoming, he adds. "All too many people handling claims still think that being honest and candid is a detriment to resolution, and that honesty is not the best policy," says Domengeaux. "We disagree wholeheartedly and have the statistics to prove it."

Domengeaux says that if he could make one change in the legal system, he would require all parties to sit down at a table and have a discussion about the claim within 60 days after it's received, and not with a neutral third party. "The parties to a case should sit down, face to face, and talk. It may not always lead to resolution, but it's going to lead to progress," he says.

Attorneys occasionally haven't allowed their clients to be present, and these discussions have been, for the most part, unsuccessful, he says, whereas claims tend to move toward resolution when everyone involved is present.

"The plaintiff's attorneys may act as a filter. Maybe they don't relay all the information, or tell them all the strengths and weaknesses of the case," he explains. "This is not always the case, but if the plaintiff personally hears me say, 'Let me tell you the things we did to care for you, but also where we have some weaknesses,' it can't be misconstrued."

The same is true at times for defense attorneys who try to suppress certain aspects of the case for fear of giving up defenses, to the point that it actually hinders resolution. In some cases, the plaintiff's attorney actually called a short time after the discussion took place, stating the claim would be dismissed primarily because Schumacher Group took the time to show the patient or family that they genuinely cared about their situation despite the defensibility or indefensibility of the case.

"Even when we have been extraordinarily honest about the care that was rendered — let's say we dropped the ball and issued a medication the patient was allergic to — I have never seen the plaintiff take advantage of our honesty in disclosing this and apologizing for what we did," Domengeaux says. "Our honesty has always benefitted the patient or their family and the provider."

The meeting is a chance to discuss the provider's care in order to explain it and to address any questions the plaintiff may have regarding the care.

"If a plaintiff doesn't get to hear directly from us on behalf of our EP named in the lawsuit, all they get to see are sanitized medical records, says Domengeaux. The plaintiff's position needs to be understood as well, in order to evaluate the claim thoroughly."

"In the end, all we are doing is fast forwarding to the point of where the case will inevitably land after years and years of protracted and expensive, often unnecessary, litigation," says Domengeaux.

Discussing the care in an open forum gives the patient or their family and the providers a chance to be heard. "Our average age of claim is extraordinarily low, likely best in the industry. This is directly a result of us having these face-to-face conversations very early on in the life of the claim," he says.

The process has reduced open time on claims by months or even years and mitigated costs associated with settling claims, according to Domengeaux, and allows those costs to be directed to those plaintiffs who deserve compensation instead of being spent on unnecessary litigation.

"When we are successful in getting all this done in the first two to three months before people are so rooted in their positions that they can't hardly find the path to resolution, we resolve claims," he says. "And most of the time, we find resolution." ■

Source

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How Much Damage Does Lawsuit Really Do to EP?

Generally speaking, when an emergency physician (EP) loses a trial, it may take him or her a long time to recover personally, psychologically, and emotionally. "But with a few rather glaring exceptions, the public is unaware of that in large measure," according to **Joseph P. McMenamin,** MD, JD, FCLM, a partner at Richmond, VA-based McGuireWoods and a former practicing EP.

"I don't have empirical data to prove this, but my perception over years of being in the field is that a successful lawsuit seems to do less damage to doctors than they often feel it does," says McMenamin. While EPs should guard their reputations carefully, the general public is largely unaware of the outcome of malpractice lawsuits, he says, and this is especially true in an ED setting. "How much does the general public know about a specific ER physician? Odds are the patient is not even going to know until he gets there who the doctor is," he says.

If an ED patient is being examined by Dr. Smith, the odds are very slim that he or she would say, "I'm not going to deal with Dr. Smith because he was sued," says McMenamin. "How often does this happen in real life? My guess is, it's pretty rare," he says.

Bitter Pill to Swallow

If an EP's insurance carrier recommends settling a lawsuit based on expert opinion that the standard of care was breached, another review by an expert with a different point of view might be in order. Depending on the circumstances, it may not be a bad idea to get a third opinion.

"But if, at a certain point, if you get a string of these, it's difficult to ignore the weight of opinions of independent experts, presumably with no ax to grind, who all reach a similar conclusion," says McMenamin.

If the EP remains objective about the expert opinions, mirroring the concept of peer review and morbidity and mortality conferences, says McMenamin, he or she may realize that, in fact, settling the case might be in his or her best interest, "bitter though the pill may be."

The EP may want to reflect on the fact that nowadays, in most specialties, and certainly in emergency medicine, says McMenamin, "getting sued is just part of the cost of doing business. It's routine. Years ago, doctors didn't get sued that much, and if they did, they hardly ever lost. If they did lose, it was shocking, but not anymore."

An EP being sued successfully in an isolated case is not rare or unheard of any longer, he explains. "It shows you've got a few battle scars, a little seniority and experience, and some gray hairs to show for your trouble," says McMenamin. "It's not going to be the end of the world. The sun will come up in the morning and you'll be able to go to back to work."

McMenamin says he was opposed to the National Practitioner Data Bank's creation, owing to concerns that it would unfairly ruin good doctors in mid-career, or impede or even terminate successful practices. "But even though I object to its existence, it doesn't seem to have had the impact I was concerned about," he acknowledges.

If nothing else, says McMenamin, a settlement buys the EP the certainty that he or she can put the matter to rest. "It means that a distraction is gone from your life and you can go back to doing what you are trained to do," he says.

It's Still Your Patient

If, in fact, the standard of care *was* breached, it's better for all parties concerned to be truthful about this, according to **Barry E. Gustin**, MD, MPH, FAAEM, a Berkeley, CA-based medical legal consultant specializing in emergency medicine and a practicing emergency physician. "If you made a mistake but you're proud of your training and experience, you can feel bad about the patient and the injuries that occurred, but don't feel bad that this led to litigation," he says.

Gustin says to take the view that "your number has come in and you've been sued. My recommendation is to cop to it. Stipulate that the standard of care was breached, talk about what it's worth, and settle it."

It's not advisable to search for loopholes to defend yourself or seek to prevent a patient from being

compensated if, in fact, the standard of care was breached, adds Gustin. "Don't get out there and lie to protect yourself because you made a mistake," he underscores. "Every doctor makes mistakes. It's just the nature of medicine, and it's what you took on when you became a doctor."

The fact that there is malpractice litigation doesn't change the fact that the plaintiff was once your patient, says Gustin. "Be remorseful and apologetic," he advises. "That's why you pay a premium to the insurance company — why do you think that money is being paid? Let them take care of it."

EP Best Judge of Own Care

McMenamin advises successfully sued EPs that the legal system is far from perfect and has many limitations in its ability to sort out good care from bad. "If your conscience tells you that you did the right thing, then a group of laypeople should have less importance than that," he says. "They don't know the truth in the same way that you do."

McMenamin also informs EPs that the legal system actively pushes in the direction of encouraging disputants to settle, regardless of the merits of the case. "That partly reflects that the courts are overloaded, and partly reflects the fact that settlement is nearly always cheaper than trial and will occur more quickly," he says.

In addition, says McMenamin, jurors are unpredictable, sometimes driven by emotional considerations and seldom well-educated in relevant subjects. "Jurors try very hard to do the right thing. But, to some extent, a lawsuit is a contest to see who has the better lawyer," he says. "To the extent that's true, an adverse outcome doesn't say much about whether an emergency physician is good or bad." ■

Sources

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Many Misconceptions on ED Nursing Liability

Successful suits are actually rare

The vast majority of emergency nurses, during their entire career, will never be involved in a lawsuit, even as a witness, much less as a named defendant, according to **Edie Brous**, RN, Esq., a New York City-based nurse attorney. "There are many misperceptions about liability exposure," she says. "Although the fear of liability has increased, actual lawsuits, in fact, have not."

The vast majority of patients do not sue their providers, even when harmed by them, and suits against nurses, in particular, remain rare. "Despite the popular narrative, most nurses do not even know another nurse who has been sued," says Brous.

About two-thirds of filed medical malpractice suits are settled or dismissed and do not survive to trial, Brous notes, adding that for an ED nurse to be successfully sued by a patient, all of these conditions have to occur:

- An injured patient has decided to sue the nurse and has convinced an attorney of a meritorious complaint before the statute of limitations has expired.
- The attorney has agreed to accept the case and have the records reviewed by an expert. "Despite pervasive rhetoric about 'frivolous' or 'junk' lawsuits, plaintiff's attorneys incur the cost of litigation, and do not accept cases they don't believe they can win," says Brous,

The case, if won, must be capable of obtaining a high enough award to compensate the attorney for the considerable expenses he or she will bear. "Plaintiff's attorneys are also constrained by ethical requirements and potential sanctions for bringing non-meritorious claims," says Brous.

- The attorney is able to secure an "Affidavit of Merit" or "Physician's Affidavit" or "Certificate of Merit."

This is an affirmation, under oath, by a board certified physician stating that the medical records and complaint were reviewed and, in the physician's opinion, to a reasonable degree of medical certainty, the claim is not frivolous, but at least contains a question of fact that should go to a jury. "In the absence of this Certificate of Merit, the case will be dismissed," says Brous.

- During the discovery period, which may include depositions, document exchange, inspection of the medical records, and independent medical examina-

tions, enough evidence is obtained that the attorney believes he or she can convince a jury that the ED nurse deviated from the standard of care and that this departure was the cause of the patient's injury.

• The attorney is able to secure a qualified expert witness who will testify, under oath, as to the standards of practice — what a reasonable ED nurse would have done in same or similar circumstances.

"The attorney must also able to secure an expert witness who will testify that the ED nurse's departure from those standards was the cause in fact of his client's injury," says Brous.

• The case isn't dismissed or settled, and goes to trial, and the jury returns a verdict against the ED nurse.

• The verdict survives an appeal and the nurse is then ordered to pay the plaintiff a certain amount in damages.

"Although rare, a lawsuit against an ED nurse is a very stressful, even traumatic experience," says Brous. "The most serious harm a sued nurse incurs may very well be emotional and psychological, not professional or economic."

In addition to the financial costs from the damage award, legal fees, and time off the job, the nurse may also need to pay a licensure defense attorney for representation before the Board of Nursing, and settlements and/or plaintiff's verdicts may be reported to the Board of Nursing, triggering a disciplinary investigation. "Potential professional harm to the ED nurse is not nearly as worrisome from a lawsuit as it is from licensure discipline," says Brous. "That is the main reason nurses need to maintain their own professional liability insurance."

Potential for More Liability

ED nurses enter the profession because they want to be the first to intervene immediately to help someone who is in trouble, says **Paula Mayer**, RN, LNC, a partner at Mayer Legal Nurse Consulting in Saskatchewan, Canada. This rapid intervention can lead to errors, which can lead to liability."With increased scope of practice comes an increase in responsibility, an increase in accountability, and the potential for an increase in liability," says Mayer.

Going through the court process means the emergency nurse has his or her practice put under scrutiny, with continual reminders of the impact the error had on the patient and family.

"Imagine being on the stand and having to admit that we messed up and hurt someone, which is the last thing any of us intend to do. It remains one of the worst things that can happen to you as a nurse," says Mayer, adding that some nurses leave the profession because they are terminated or have their licensure revoked, or because of the emotional devastation caused by the experience of being sued.

Get Independent Counsel

Since the facility attorney's first priority is to protect the institution, not the individual emergency nurse, says Mayer, nurses should retain their own independent counsel as soon as possible if named in a lawsuit launched against his or her institution. Court decisions may also be reported by the legal system to state licensing bodies, and trigger discipline up to and including revoking a nurse's license to practice. The single most effective thing an emergency nurse can do to reduce liability is to hone interpersonal skills, advises Brous. "The manner in which a patient is treated determines, more than any other factor, whether that patient will want to sue a provider," she says. ■

Sources

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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 true regarding settling a plaintiff's claim alleging ED malpractice, according to **Michael M. Wilson**, MD, JD?
   A. A plaintiff's lawyer would recommend that a case be settled when he thinks that the client would be reasonably taken care of over his or her lifetime, says Wilson, assuming a catastrophic, disabling injury, and that the amount to be paid would be reasonable considering the strengths and weaknesses of the case.
   B. Under no circumstances would the hospital lose its assets if it were to be found liable for a catastrophic injury.
   C. It is never advisable to settle claims or cases before all of the witness depositions and expert depositions have been taken.
   D. In catastrophic injury cases, there is no advantage whatsoever to the defendant to set up a Special Needs Trust, which accepts the settlement proceeds and pays them to the plaintiff under a plan approved by a judge.

2. Which is true regarding the process used by the Schumacher Group to manage claims alleging malpractice by an EP, according to **Ryan Domengeaux?**
   A. In-person meetings with the plaintiff and family present tend to result in more claims going to trial.
   B. Candid discussion with the plaintiff or family and their counsel only take place if the standard of care was clearly breached.
   C. Discussions about claim resolution are far more likely to be successful if the plaintiff or family is not present.
   D. Having face-to-face conversations with providers, patients and family, and counsel present has reduced open time on claims by months or years.

3. Which must occur for an emergency nurse to be successfully sued, according to **Edie Brous**, RN, Esq?
   A. The plaintiff's attorney needs to secure an affirmation, under oath, by a board-certified physician stating that the claim at least contains a question of fact that should go to a jury.
   B. During the discovery period, enough evidence is obtained that the attorney believes he or she can convince a jury that the ED nurse deviated from the standard of care and that this departure was the cause of the patient's injury.
   C. The attorney is able to secure a qualified expert witness, who will testify, under oath, as to what a reasonable ED nurse would have done in same or similar circumstances.
   D. All of the above.

CNE/CME OBJECTIVES

After completing this activity, participants will be able to:

1. Identify legal issues related to emergency medicine practice;
2. Explain how the legal issues related to emergency medicine practice affect nurses, physicians, legal counsel, management, and patients; and
3. Integrate practical solutions to reduce risk into daily practice. ■

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