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Texas Emergency Physician Sues Hospital in EMTALA Whistleblower Claim

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A U.S. District Court in Texas allows a physician's retaliation claim against the hospital that allegedly terminated his privileges for reporting violations of the Emergency Medical Treatment and Labor Act (EMTALA).

The Case of Dr. Walter Zawislak v. Memorial Hermann Hospital System[1]

Memorial Hermann Hospital suspended the medical staff privileges of Dr. Zawislak, purportedly for substandard care, and reported the adverse action to the National Practitioner Data Bank (NPDB). Consequently, his employer, Team Health, terminated his contract to work at Memorial Hermann.

Dr. Zawislak claimed that the hospital rescinded his clinical privileges in retaliation for disclosing and reporting EMTALA violations committed by the hospital. He alleged that two unstable emergency department (ED) patients were transferred from Memorial Hermann to another trauma center because Memorial Hermann's trauma surgeon on-call was either unavailable or unqualified to manage the patients' injuries. He reported the trauma surgeon's conduct to the ED medical director and the hospital's "Root Cause Analysis Committee."

Unable to work out his differences with the hospital, Dr. Zawislak sued Memorial Hermann under EMTALA's whistleblower provision for money damages and equitable relief, and also filed a state law claim of defamation against the hospital for publishing in the NPDB that it took an adverse action against his clinical privileges for the reason of providing substandard care.

The hospital asked the court to dismiss Dr. Zawislak's claim of defamation arising from the NPDB report because he failed to exhaust his

administrative remedies with the Department of Health & Human Services (HHS — the agency responsible for the physician data bank); and/or because it was immune from suit under the Health Care Quality Improvement Act ("HCQIA").

Memorial Hermann also petitioned the court to dismiss the EMTALA claim, contending that Dr. Zawislak did not qualify as a whistleblower under EMTALA's anti-retaliation provision.

The Court's Opinion[1]

1. "Exhaustion." The hospital argued that Dr. Zawislak did not follow the procedures set out in the applicable federal regulations[2] to dispute the accuracy of Memorial Hermann's report to the NPDB. The HHS permits a physician to dispute the accuracy of an NPDB report by filing a written dispute with the Secretary of Health and Human Services within 60 days of receiving the report.[2] Dr. Zawislak first asked Memorial Hermann to retract its report, then waited another 120 days before he sent a dispute letter to HHS. Therefore, the court determined that Dr. Zawislak did not follow the procedures set out in the regulations.[1]

However, the court noted that the HHS regulatory language is *permissive*, not mandatory, providing that a physician "may" dispute the accuracy of a report by requesting a revision of the report.[2,3] Thus, disputing the accuracy of the report with the Secretary of Health and Human Services is not a prerequisite to filing suit.[1]

The court also pointed out that Dr. Zawislak did not actually seek correction of the report. Instead, he complained of damages he suffered as a result of the hospital's already filed report.

Therefore, since the procedures under the regulations[4] only provide for the correction of a report, the Court held that Dr. Zawislak did not have to resort to or "exhaust" administrative remedies before filing suit.[1]

2. Immunity Under the Healthcare Quality Improvement Act (HCQIA). Congress passed the HCQIA to provide for effective peer review and nationwide monitoring of incompetent physicians. Congress also provided qualified immunity for peer-review contributors to encourage them to participate in the process.[5,6]

For immunity to apply under the HCQIA, the "professional review action"[7] must be taken:

(1) in the reasonable belief that the action was to further quality health care;

(2) after a reasonable effort to obtain the facts of the matter;

(3) after adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances; and

(4) in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after meeting the requirement of paragraph (3) [above].[8]

The hospital is presumed to have complied with each of the four elements of the law, unless the physician can rebut the presumption by a preponderance of the evidence.[8] Here, the court was convinced that Dr. Zawislak's allegations were sufficient to suggest that the hospital failed to make a "reasonable effort to obtain the facts." First, the peer-review committee did not

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even consider the actions of the on-call trauma physicians or Dr. Zawislak's treatment of the patients at issue. Second, since Dr. Zawislak claimed that the hospital suspended his privileges in retaliation for reporting the on-call physicians at Memorial Hermann for transferring unstable patients in violation of EMTALA, the jury could find that the hospital's decision to transfer the patients was not based on considerations for quality health care, but was instead intended to protect Memorial Hermann's on-call physicians and other hospital personnel.[1] Therefore, the court rejected the hospital's plea that it was immune from suit under the HCQIA.

It also is worth noting that even if the court granted the hospital HCQIA immunity, it would not totally defeat Dr. Zawislak's EMTALA claim of retaliation. Dr. Zawislak sought both compensatory money damages and equitable relief under the EMTALA count of his complaint. But the HCQIA confers immunity only from liability for money damages; it does not protect hospital defendants from suits for other forms of relief, such as equitable relief.[9,10] Examples of equitable relief would be the court requiring the hospital to reinstate the physician's privileges, or require the hospital to correct the NPDB report, notwithstanding the procedural requirements of HHS's regulations.

3. EMTALA Whistleblower Claim. If a physician or hospital employee qualifies as a whistleblower, he or she can sue the hospital for any personal harm suffered as a direct result of the hospital's violation of the whistleblower provision or any other requirement of the statute.[11] The damages available under such an EMTALA lawsuit are those damages available for personal injury under the law of the state in which the hospital is located, and such "equitable relief" as is appropriate.[11]

Memorial Hermann contended that Dr. Zawislak was not a whistleblower according to EMTALA and, therefore, could not sue the hospital under EMTALA.[1]

EMTALA's federal whistleblower provision only protects physicians and hospital employees from retaliation by a Medicare-participating hospital for two types of actions.[12] A hospital may not penalize or take adverse action:

- against a physician (or a qualified person acting at the direction of a physician) because the physician refuses to authorize the transfer of an individual with an emergency medical condition that has not been stabilized; *or*
- against any hospital employee because the employee reports a violation of a requirement of this section (EMTALA).

The Centers for Medicare and Medicaid Services (CMS — the federal agency within HHS charged with the interpretation and enforcement of EMTALA) regulations on this issue simply parrot the statute.[13] However, CMS' interpretive guidelines expand the interpretation to add that a hospital employee reporting an *alleged* violation of EMTALA is also protected by the regulation.[14]

Hermann Memorial first argued that because Dr. Zawislak did not allege that he refused to transfer any unstable emergency room patients, he did not fall within the first class of individuals protected by the statute. Dr. Zawislak claimed there were two occasions in which unstable emergency room patients were transferred to other trauma centers because the hospital's on-call trauma surgeon refused or was unqualified to treat the patient's injuries. He did not claim on either occasion that he refused to transfer the patients. In one instance, he stated that he "challenged" the on-call physician's transfer orders, but, nevertheless, he still transferred the patient to another trauma center. Therefore, the court held that Dr. Zawislak did not fall within the first class of whistleblowers because he failed to allege a situation in which he refused to authorize the transfer of an unstable patient.[1]

Next, the hospital argued that Dr. Zawislak was clearly not a hospital employee, since he was employed by Team Health, the company which held the ED contract and, therefore, he did not fall within the second class of protected individuals.[1]

But it was not so straightforward. First, the court could not identify any HHS/CMS regulations or case precedent construing the meaning of "employee" in the EMTALA whistleblower provision.[1] Second, the court couldn't buy the notion that because the law affirmatively prohibits hospitals from taking adverse action against "any hospital employee," it would impliedly allow hospitals to take adverse action against members of its own medical staff who observed and reported EMTALA violations. That interpretation would seem to contradict the very purpose of EMTALA, so the court ruled that, "The legislative purpose of the statute is best served by construing it to prohibit participating hospitals from penalizing physicians with hospital privileges."[1]

The court noted that, "Physicians in the hospital's 'emergency room,'" [courts seem to have a problem saying "emergency physicians"], "have an advantageous position to observe whether a hospital is encouraging and instructing physicians to dump patients."[1] Accordingly, the court determined that EMTALA's whistleblower provision must be construed to include physicians with hospital privileges within the definition of "hospital employee," and it denied the hospital's motion to dismiss Dr. Zawislak's EMTALA claim.[1,15]

Additional Comments

Interestingly, the hospital didn't question whether Dr. Zawislak actually "reported" the alleged EMTALA violations in the manner intended by the statute. He reported the incidents to his ED medical director and the hospital's "Root Cause Analysis Committee." "Reporting" EMTALA violations typically means providing the information to the federal agency charged with enforcing EMTALA, which is CMS (or via the state agency that serves as the survey agent for CMS in that state). There is no case decision on this issue, and CMS' regulations and interpretive guidelines do not address it either, although there is one regulation that requires a *hospital* to report to CMS or the state survey agency a transfer violation if the hospital receives an inappropriate transfer of an unstable patient.[16]

There have been other EMTALA whistleblower cases. For example, in the case of *O'Connor v. Jordan Hospital*, a nurse and 38-year veteran employee of the hospital alleged she was fired for reporting an EMTALA violation by her hospital to the Massachusetts Department of Public Health, which is the state survey agency responsible for EMTALA investigations for CMS in Massachusetts.[17] She informed federal authorities that the hospital transferred a diabetic woman who was 6 months pregnant with twins to another hospital 26 miles away without first performing a medical screening exam. The patient suffered serious complications after an emergency C-section on arrival at the second hospital.

Allegedly, Ms. O'Connor consulted the hospital's attorney prior to reporting.[17] The attorney told her to "self report" before the hospital that received the transfer reported them, as it would be required to do under CMS regulations[16] or face termination from Medicare itself for failure to report the transferring hospital.[18]

CMS subsequently conducted a full-scale review of the hospital's EMTALA compliance that confirmed the inappropriate transfer violation as reported, and found four additional EMTALA violations as well, exposing the hospital to potential termination from Medicare and $250,000 in civil monetary penalties. The same day CMS' investigators showed up, the hospital fired nurse O'Connor, only six months after she reportedly received an exemplary performance evaluation.[17,19]

In the *O'Connor* case, the elements required in the EMTALA whistleblower provision were clear: she was definitely an employee of the hospital and she reported the case to the proper governmental authorities.[17]

In another case, *Ritten v. Lapeer Regional Medical Center (LRMC),* a Michigan obstetrician also brought an EMTALA retaliation claim. Dr. Ritten alleged his staff privileges were summarily suspended because he refused to transfer a patient with an emergency condition that had not been stabilized, in violation of EMTALA, which fits nicely into the first category of protected actions in EMTALA's whistleblower clause.[12,20]

The patient in question arrived at LRMC's emergency department and was promptly triaged to the hospital's labor and delivery unit. She was 20 weeks pregnant with vaginal bleeding and moderate cramping. Dr. Ritten examined the patient (performed the hospital's EMTALA-mandated medical screening examination) and determined her membranes had ruptured and that she was in labor. He deemed the proper treatment was to evacuate the uterus.

Somehow the hospital CEO, Mr. Barton Buxton, got involved and allegedly suggested transferring the patient to another facility, ostensibly because it was against hospital policy to "perform an abortion." Dr. Ritten responded that an abortion was "inevitable" because "the baby's not viable" and the patient's membranes were "already ruptured."[20] The hospital's chief nursing officer then asked another obstetrician to examine the patient, and that obstetrician determined the membranes were not ruptured, just "hourglassing," and that the patient was not in labor and could be transferred.[20]

After this, Mr. Buxton allegedly told Dr. Ritten that he wanted the patient transferred out, and then threatened Dr. Ritten with loss

of his job if he didn't do so. Dr. Ritten protested against the transfer, allegedly advising Mr. Buxton that "she's not stable for transfer" and could "deliver at any point in time."[20] Nevertheless, Dr. Ritten did contact another hospital to discuss transferring the patient, but was told that the patient would not be accepted in her present condition, as described by Dr. Ritten. Mr. Buxton then called the other hospital himself, stating that another LRMC obstetrician had reached a different conclusion, and that he'd have that physician call to report her findings for possible transfer. The patient went into active labor before the second obstetrician could call, and the patient delivered not long after, but the baby did not survive.[20]

As in the *Zawislak* case, the hospital and its CEO claimed immunity under the HCQIA, which the court quickly denied, stating, "Taking the allegations as true, no inferences would be required to conclude that Plaintiff's refusal to transfer the patient 'was a motivating factor' in Buxton's decision to suspend his privileges."[20]

They also claimed that Dr. Ritten was wrong about whether the patient, in fact, had an emergency medical condition and whether the patient was unstable for transfer. The court held that whether Dr. Ritten was right or wrong was irrelevant to his EMTALA retaliation claim. He clearly had a "reasonable and good faith belief that the opposed practices were unlawful."[20]

Moreover, the court stated, "A hospital is not free to discount a physician's reasonable evaluation and then retaliate against the physician with impunity, on the ground that it did not accept or agree with the physician's stated finding of an emergency medical condition."[20]

Conclusions

Litigation under EMTALA's whistleblower provision is still in its infancy. It remains to be conclusively determined when physicians will qualify as a hospital "employee" for purposes of protection under the law, and exactly what constitutes a proper "reporting" of an alleged EMTALA violation to trigger the whistleblower protection. Furthermore, it behooves physicians to know that not all refusals to partake in a hospital's violations of the law are protected; only the refusal to authorize an unstable transfer is covered under the EMTALA whistleblower umbrella. ■

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1. *Walter Zawislak v. Memorial Hermann Hosp. Sys.*, No. H-11-1335 (S.D. Tex. Oct. 26, 2011).
2. 45 C.F.R. § 60.16(b).
3. *See also* 42 U.S.C. § 11136; Congress specifically authorized the Secretary of HHS to "promulgate by regulation... procedures in the case of disputed accuracy of the information."
4. 45 C.F.R. § 60.16.
5. *See* 42 U.S.C. § 11111(a).
6. *See Poliner v. Texas Health Sys.*, 536 F.3d 368 (5th Cir. 2008).
7. 42 U.S.C. § 11151(9). The HCQIA defines a "professional review action" as an action or recommendation of a professional review body which is taken or made in the conduct of professional review activity, which is based on the competence or professional conduct of an individual physician (which conduct affects or could affect adversely the health or welfare of a patient or patients), and which affects (or may affect) adversely the clinical privileges, or membership in a professional society, of the physician."
8. 42 U.S.C. § 11112(a).
9. 42 U.S.C. § 11111(a).
10. *See also Singh v. Blue Cross Blue Shield of Massachusetts, Inc.*, 308 F.3d 25, 44 (1st Cir. 2002).
11. 42 U.S.C. § 1395dd(d)(2)(A).
12. 42 U.S.C. 1395dd(i).
13. 42 C.F.R. 489.24(e)(3).
14. CMS State Operations Manual (SOM), Appendix V — Interpretive Guidelines — Responsibilities of Medicare Participating Hospitals in Emergency Cases – EMTALA, Effective May 29, 2009; revised July 16, 2010. Available at: http://www.cms.hhs.gov/manuals/Downloads/som107ap_v_emerg.pd. See Tag A-2401.
15. To support its position, the Texas court cited a U.S. Supreme court case which stated: "In rare cases where application of the literal terms of the statute will produce a result that is 'demonstrably at odds with the intentions of its drafters,' those intentions must be controlling." *Griffin v. Oceanic Contractors, Inc.*, 458 U.S. 564 (1982).
16. 42 C.F.R. 489.20(m).
17. *Margaret O'Connor v. Jordan Hospital*, et al, Case #1:10-cv-11416-MMB (D.Ct. Mass. Dec. 9, 2011) (amended complaint filed December 9, 2011).
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20. *Ritten v. Lapeer Regional Medical Center*, 611 F.Supp.2d 696 (E.D. Mich. 2009).

Don't Hide Details About Suits or Settlements

"Candor is essential"

Emergency physicians (EPs) named in lawsuits likely won't be eager to answer detailed questions about their legal problems years down the road, but there are situations in which they'll need to do so.

"The natural tendency is that you would like to forget about it and have it go away," says **Stephen A. Frew**, JD, vice president of risk consulting at Johnson Insurance Services and a Rockford, IL-based attorney. "To think people are not going to ask about it is wishful thinking."

If the EP seeks employment with a group, or requests privileges at a hospital, he or she should be ready to explain any previous suits or settlements. "The EP may have to explain to their colleagues why the practice is taking this particular hit on their loss experience," adds Frew. "Most physicians in the group are going to know an honest explanation when they hear it. That is the only thing that is pretty certain, so candor is essential."

A single loss, even if large, does not automatically hurt an emergency medicine group, he explains, and an insurer reviewing the group's loss experience will want to know what the group has done to improve its risk profile, such as changes in policies and procedures to reduce risk. "They are looking at the group as a whole, and they are expecting some occasional losses," says Frew.

When an individual EP applies for privileges, however, he or she may be viewed in an unfavorable light after disclosing a previous settlement.

"In the state of Florida, they don't give you a license if you've been sued three times. Medical organizations were unsuccessful in convincing the legislature that lawsuits don't equal incompetence," says Frew. "We have the same kind of attitude in some hospitals: we're not going to take anybody who's ever been sued."

Even though a judgment or settlement doesn't necessarily mean any malpractice has occurred, says Frew, there's always the chance that the EP named in the suit will be penalized going forward. He gives these recommendations for an EP to follow after a settlement or verdict in a suit by a patient:

• The EP should be prepared to address the facts of the suit.

"The EP needs to manage how it will be presented," he says. "Going into a privileging situation, a new employment situation, or a new insurance policy, you need to know what you are going to tell people about this event."

EPs should work with their trial attorneys to articulate a professional and understandable explanation about the suit, Frew advises, or seek advice from a physician counselor if one is available through the insurance company.

"The EP may validly feel that they were wronged in the verdict and that it was a bad outcome that bore no resemblance to the facts," says Frew. In this case, he says, EPs need help from an experienced professional in order to present a positive image of themselves in the future.

"The reality is that trying to minimize, or not disclosing, these things — especially since they are going to be in the National Practitioner Data Bank anyway — seriously hurts the applicant," says Frew.

• The EP should obtain a letter of explanation from an attorney involved in the case.

The letter should give details on the facts involved, witnesses who testified on the EP's behalf, and the financial decision-making that went into the decision to settle.

"This gives an honest, credible explanation that makes the EP look reasonable, even though there was a settlement," says Frew. The attorney's letter is particularly helpful if a jury made a decision to award the plaintiff money, he notes, because "then it is a little harder to convince some people that although they returned a verdict, there was nothing to support it."

• If an error was made that harmed a patient, the EP should specify what actions he or she took to improve professionally, such as additional education or time spent proctoring.

"This is especially important if the EP slipped up when most people wouldn't have," Frew says. The goal is to convince others that the EP is taking responsibility to be sure the mistake doesn't happen again.

"Remember that the person hiring has talked to EPs who have screwed up much worse than you," adds Frew. "If you appear to be conscientious in addressing it, they will generally look at your attributes without necessarily focusing on this claim."

At the same time, cautions Frew, being overly remorseful, angry, or upset by the incident may cause the future employer or credentials committee to question whether the EP will be a strong practitioner under ED stress.

• The EP should avoid placing blame on others.

"The biggest error I see in these situations is attempting to blame somebody else, even if it *was*

their fault and not yours," he says. "The physicians or board reviewing the application will wonder if the EP is prone to putting off errors on other people."

It is not uncommon for EPs to get sued for something a specialist did, for instance. "The specialist may have come in, took over, made a mistake, and everybody who touched the patient got sued," says Frew. "Settlements often don't allocate fault, and make it appear everyone was equally to blame."

In such a case, Frew says the EP should obtain a letter from his or her attorney placing the blame on the responsible parties. "The EP might say, 'I don't feel comfortable criticizing others, but if you'd like to read my attorney's explanation, it's pretty explicit how this occurred,'" he says.

• **The EP should be forthcoming with details.**

When the EP is asked to provide the specifics of any previous settlement or suit on an application, he or she may just give the name, date, location, and outcome. "This is only going to result in an inquiry for more details," says Frew.

Another reason to give a detailed, frank accounting of what occurred is that once a committee wants to hire the EP or grant privileges, the hospital board will still need to be convinced.

"The board is still the final arbiter of whether or not you are going to get privileges, and you won't be there to answer their questions," says Frew. Medical officers and credentialing committees armed with only sparse details may struggle to explain to the board why they want to hire somebody with a past malpractice suit.

"By giving them the ammunition to defend you, they will often be an advocate," he adds. "But if you leave them to guess about what happened, they will have doubts of their own."

Some physicians on the credentialing board will have had their own experiences with malpractice allegations, notes Frew, and will be looking for signs that the EP has come out of it stronger and wiser. "If the EP can discuss an incident openly, frankly, and credibly, I have not seen most issues like this be a problem," he says. ■

Source

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Suit-prone EP? Consider Communication Style

The view that every emergency physician (EP) is going to get sued sooner or later is "a bit of an oversimplification," according to **Stephen A. Frew**, JD, vice president of risk consulting at Johnson Insurance Services and a Rockford, IL-based attorney.

"Some people are going to get sued a lot more than others because of the way they communicate," he says. "They are not necessarily bad doctors."

There is a small group of doctors in every area of practice, including emergency medicine, who are particularly litigation-prone, says Frew. "Frequently, a very small proportion of doctors in a given specialty represent more than 80% of claims," he says. "It used to be that if a doctor was suit-prone, nobody cared as long as they were winning the lawsuits."

The prevailing attitude now is that the mere fact that an EP is being sued on multiple occasions is costing the group money and credibility they don't want to risk, says Frew, adding that EPs sued frequently often need to work on their patient communication styles.

Individual hospitals are beginning to develop internal programs that focus on proctoring communications skills for physicians with low patient-satisfaction scores, he reports.

"If I'm working with a group and a doctor is viewed as a good doctor, but gets sued frequently, we try to get them into one of the intense patient communications professional training programs that are starting to become available," Frew says. ■

Don't Handle Nursing Investigation Alone

Seemingly innocent statements may backfire

If an ED nurse is contacted by the state board of nursing about a medication error that harmed a patient, his or her first instinct might be to state, "I told them this would happen because we didn't have enough staff!"

"An opposing attorney will turn that back around into, 'Well, if you knew it was unsafe, what else did you do to prevent it?'" says **Karen Jarboe**, RN, CEN, CCRN, a legal nurse consultant

specializing in emergency medicine and a senior clinical nurse with the adult ED at University of Maryland Medical Center in Baltimore.

Any complaint from a patient or family member could result in an ED nurse becoming the subject of an investigation by the state board of nursing, adds Jarboe, and in this case, the first step should be to contact an attorney.

"Don't let anyone talk you into representing yourself," she warns. "Your license is your livelihood, and trying to represent yourself could backfire." She gives these recommendations:

• ED nurses should retain a nurse attorney or one who specializes in administrative law.

"Remember, the role of the state nursing board is to protect the public," she says. "They do not advocate for the best interest of the nurse."

• ED nurses should not discuss the issues with anyone except their attorney.

"Refer any phone calls to your attorney, including phone calls from the investigator," says Jarboe. "Speaking or responding in writing on your own can be detrimental to your case."

• ED nurses should never post anything about the investigation on a blog or other website, as many nursing boards monitor these sites.

"Be careful with social networking sites — they're not as private as you think," says Jarboe. "Many privacy settings can be easily overridden by an IT person."

An opposing attorney will use information about activities outside work to raise doubts about your values, beliefs, and character. "Some of those fun shots from a night of drinking and dancing on the bar end up being very detrimental," she says.

In addition, many ED nurses post comments throughout the day about their shift. "While this may seem innocent at the time, using code words or room numbers to describe your patient, as well as posting pictures from your nursing unit, can easily turn into a [Health Insurance Portability and Accountability Act] violation," says Jarboe.

In one case on which Jarboe consulted, an ED nurse commented on Twitter about a patient's HIV status. "A friend of the family saw the post and filed a claim. The nurse was immediately terminated," she says.

In another case, an ED nurse posted a photograph of a group of staff members while working, with a tracking board listing patient names visible in the background. "A coworker reported it, and was able to enhance the photo so 11 patient names were clearly visible," says Jarboe. "All nurses in the photo received disciplinary action."

• ED nurses should be truthful.

It's a mistake to try to lie your way out of the situation during an investigation. "Attorneys are very good at asking the same question 10 different ways. If you lie, you will never have the same response," says Jarboe. "Truthful answers will be consistent no matter how many times the question is asked."

• ED nurses should not keep personal notes about an incident or the investigation.

The notes you keep are discoverable, says Jarboe, and you will find yourself trying to explain why you knew a particular incident was going to be a problem.

"Let your attorney do the documenting and keep notes. His or her notes are attorney-client privileged," she says.

• ED nurses should never take home medical records or copies of medical records.

Medical records are considered to be hospital property and confidential patient information. "Not only will you be the subject of an internal investigation, you will quickly find yourself facing criminal charges," says Jarboe. ■

Source

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Learn Info *Before* Legal Problems Occur

ED nurses shouldn't wait to be the subject of an investigation to become familiar with the hospital's risk management department, says **Karen Jarboe**, RN, CEN, CCRN, a legal nurse consultant specializing in emergency medicine and a senior clinical nurse with the adult ED at University of Maryland Medical Center in Baltimore.

"Make a simple phone call, and your risk manager will be happy to help. Part of their job is prevention and education," she says. "Ask your leadership to schedule a time for your risk manager to attend a staff meeting."

If a serious error occurs in the ED, Jarboe says

that the ED nurse involved should contact risk management and follow their directions. "It's so much easier when they know right away," she says. "They can look at the chart and talk to anyone involved. It's much more difficult to backtrack years down the road."

ED nurses should find out the extent of their insurance coverage and the scope of that representation, recommends Jarboe."If you have individual malpractice insurance, call your carrier," she says. "If you are the subject of a state board of nursing investigation, you might find that you need to retain your own attorney."

A common misconception is that the hospital's risk management department will provide insurance coverage in all instances. While the hospital's risk management department will cover the hospital if an agency nurse makes a mistake, adds Jarboe, they will most likely not cover the agency nurse involved.

"Chances are, if you are volunteering or practicing in some way outside of your institution, your risk management department is not going to cover you," adds Jarboe. ■

Are You Being Investigated? Mount a Vigorous Defense

Use experts to help you

If an emergency physician (EP) learns he or she is being investigated by the medical board, this should be taken seriously but not personally, advises **Michael Blaivas**, MD, professor of emergency medicine in the Department of Emergency Medicine at Northside Hospital Forsyth in Cumming, GA.

"The key is, this is all just part of doing business," he says. "You cannot take it personally. Just like a medical-legal case, things move in slow motion, and so should your emotions. Don't get fired up and don't panic."

EPs should contact their malpractice insurance carrier if the issue involves mismanagement of a patient with a negative medical outcome, says Blaivas, and an attorney may be provided.

Some EPs have hired attorneys themselves who retained Blaivas to help defend them in front of the medical board. "If the allegations from the board seem serious enough to you and an attorney, then defend yourself just like this was an actual malpractice case," he advises. "Mount a good defense, and use available literature and experts to help you."

Make sure that any hospital investigation is held under peer-review protection, adds Blaivas, so that a plaintiff's attorney cannot obtain it, and one day show it to a jury.

Anything the EP says about the investigation can be held against him or her, warns Blaivas. "This is not the time to be hasty or angry. This is the time to play lawyer. That does not mean threaten to sue someone," he says. "It means shed all emotion and pretend you have nothing at stake."

Look at the situation from a third person's point of view, advises Blaivas, and tell investigators you will review the matter and get back to them. "Then go home and start doing some homework," he says. "This is definitely the time to put on your analytical hat. Start reading to see if anything published backs up the care you gave and your decision-making process."

Be Neutral but Honest

If a case is going to be settled or goes to trial, Blaivas says the EP involved should first check what minimums exist for reporting requirements in the state. "In some cases, you may be able to push for settlement just below a minimum," says Blaivas.

Blaivas says that the EP should prepare a standard explanation about the case, putting a positive spin on it while being truthful.

"Trying to hide things can backfire. Lies tend to get very complicated to keep track of," he says. "Even if there is something embarrassing, it is best to be honest and swallow your pride." Blaivas gives this example: "It was clearly appropriate care, but a very unexpected outcome and a tragic one. I was advised it was easier to settle than risk going forward."

"There are many times when a physician is pressured to settle by the insurance company, group, or hospital," he says. "That is not a great excuse, but it works."

If asked about an old case in a deposition or trial, Blaivas says the EP should be clear that he or she believes the care provided was appropriate, such as prefacing statements by saying, "I guess the jury thought..."

"Make it clear you do not agree that you did

a bad job. There may or may not be an opportunity to do this. You might just get asked some cold hard facts," he says, adding that some EPs have had many suits and settlements against them. "You can always compare yourself to the people that have been sued eight or 10 times," he says. "I have seen those folks getting deposed. They don't seem to bat an eye at it."

Above all, says Blaivas, the EP should not allow a lawsuit to affect his or her personal or business life. "So many people let lawsuits really do a lot of damage to them in all aspects of their life," he says. "That is how a suit really makes you pay." ■

Source

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Nursing Delays May Lead to Malpractice Suits

Did an emergency physician write an order for a magnetic resonance imaging (MRI) scan, but one cannot be obtained because the machine is being serviced? If so, the chart should reflect that the ordering physician was advised of the delay.

"It then becomes a physician decision as to transferring the patient to another facility to obtain the MRI, waiting until an MRI can be obtained in-house, or some other plan," says **Edie Brous**, RN, Esq., a New York City-based nurse attorney.

If it is not possible to implement an order immediately, she advises, the ED nurse should notify the ordering physician and document the reason for any delay, as well as the specific physician notified.

The failure to accurately capture the sequence of events in the medical record can make defending a future claim more difficult, Brous explains.

"Nursing delays that compromise the clinical status of a patient could lead to allegations that the nursing staff was responsible for deterioration in the patient's condition," she says.

If interventions are delayed, an ED nurse can be accused of malpractice in a lawsuit, or charged with professional misconduct or unsafe practice by a licensing board, warns Brous.

Brous says that the allegations are generally that the nurse failed to monitor the patient for status changes/foreseeable complications, failed to recognize status changes/foreseeable complications, failed to intervene with status changes/foreseeable complications, failed to notify a physician of status changes/foreseeable complications, and/or failed to pursue concerns to resolution.

To reduce legal risks involving delayed ED nursing interventions, use these strategies:

• ED nurses should clearly document which specific physician was notified of what specific findings and concerns at what specific time.

Charting such as "MD aware" isn't sufficient to indicate that the nurse identified clinical information in a timely matter, says Brous.

• ED policies and procedures should address the frequency of reassessment for triaged patients awaiting physician evaluation.

A patient who appears stable in triage may deteriorate rapidly after being assigned a non-emergent acuity classification, says Brous. "Because the ED is a diagnostic area, providers must maintain an index of suspicion for worrisome conditions," she adds.

Failure to triage someone accurately, resulting in delayed treatment that results in a poor outcome, puts the triage nurse "right in the forefront of litigation," says **Paula Mayer**, RN, LNC, a partner at Mayer Legal Nurse Consulting in Saskatchewan, Canada.

With the increased emphasis on reducing wait times in health care, nurses' decisions are subject to greater scrutiny by hospital authorities and the courts, says Mayer. "There are cases of triage nurses being sued for delays in treatments due to improper triage, and some of them have been decided for the plaintiff," she notes.

• ED nurses should inform administrators if wait times are outside the standard of care.

The average wait time to see an emergency physician increased from 22 to 30 minutes from 1997 to 2006, according to one study, and the wait time for a heart attack patient increased from 8 minutes to 22 minutes.[1]

"Nurses need to be reporting to their administration if this is occurring in their ED, as the standard of care for myocardial infarction is an ECG within 10 minutes of the patient presenting

to the ED with chest pain." says Mayer. " If this standard of care is not being met, the hospital is responsible for the adverse outcome."

If delays in ED care are due to administrative issues, this needs to be identified to hospital administration so that the issues can be addressed, stresses Mayer, and failure by ED nurses to identify such problems to administration puts the nurse at increased risk. "The courts won't care how busy you are — just that you met the standard of care," she says.

REFERENCE

1. Wilper AP, Woolhandler S, Lasser KE, et al. Wait to see an emergency department physician: U.S. trends and predictors, 1997-2004. *Health Affairs* 2008;27(2):w84-w95.

Sources

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CNE/CME OBJECTIVES

After completing this activity, participants will be able to:

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

CNE/CME INSTRUCTIONS

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

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

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

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

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

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

CNE/CME QUESTIONS

1. Which of the following is recommended in the event an emergency physician (EP) is successfully sued, according to **Stephen A. Frew**, JD?
   A. The EP should not provide a credentialing board with a letter of explanation from an attorney involved in the case.
   B. The EP should avoid acknowledging to a credentialing board that an error was made that led to a patient's bad outcome.
   C. The EP should not obtain a letter from an attorney placing blame elsewhere, and should instead clearly state that an error was someone else's fault in his or her own words.
   D. The EP should provide a detailed, frank accounting of what occurred so that medical officers and credentialing committees are able to explain to the hospital board why they want to hire somebody with a past malpractice suit.

2. Which of the following is recommended for emergency nurses to avoid allegations of delayed intervention in the event of a malpractice lawsuit, according to **Edie Brous**, RN, Esq.?
   A. If it is not possible to implement an order immediately, the ED nurse should notify the ordering physician and document the reason for any delay, as well as the specific physician notified.
   B. It is not advisable for the ED nurse to specify which EP was notified of a specific finding or concerns.
   C. Emergency nurses should use only general terms such as "MD aware" and avoid specifics regarding delays in interventions, as it is easier for a defense attorney to prove that the nurse identified clinical information in a timely manner.
   D. ED nurses should be less concerned with wait times that fall outside the standard of care during times of extreme crowding, as there is less chance of a patient proving an adverse outcome was caused by a preventable delay.

3. Which is recommended in the event an ED nurse is being investigated by the state board of nursing, according to **Karen Jarboe**, RN, CEN, CCRA?
   A. In most cases, the emergency nurse should not contact an attorney.
   B. The ED nurse should retain an attorney who specializes in administrative law, or a nurse attorney.
   C. The ED nurse should be aware that the hospital's risk management department will always provide insurance coverage, even for agency nurses.
   D. The ED nurse should keep detailed personal notes on the investigation.