ED Legal Letter™

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

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

AHC Media

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September 2012
Vol. 23 • No. 9• Pages 97-108

Liability Reform Lessons from the 'Common Law'

Robert A. Bitterman, MD, JD, FACEP
Contributing Editor

Tort reform advocates and legislators need to better understand the impact of the common law when drafting language to curtail frivolous litigation or establish damages caps.[1] Two recent state Supreme Court cases, one from South Carolina and one from Missouri, dampen the cause of medical malpractice liability reform.

South Carolina: *Grier v. Piedmont Medical Center*[2]

Evelyn Grier, as the administrator of the estate of Willie James Fee, sued Piedmont Medical Center for the wrongful death of Mr. Fee. As required by South Carolina's tort reform law enacted in 2005, Ms. Grier filed a notice of intent to sue and an "affidavit of merit" from an expert witness attesting that the hospital negligently violated the standard of care in treating Mr. Fee's bedsores, resulting in his death from sepsis.[2,3]

The hospital pointed out to the circuit court that the plaintiff's expert was a nurse, not a physician, and was, therefore, not legally qualified to opine as to the cause of death. The nurse was qualified to testify that the hospital's staff breached the standard of care in treating the bedsores, but not to whether the hospital's breach actually caused Mr. Fee's sepsis and subsequent death.

The court agreed that the nurse was not qualified to address the cause of death and, furthermore, it held that a proper affidavit must include a statement by the expert that the breach of the standard of care was a proximate cause of the patient's death. The court graciously gave Ms. Grier 30 days to submit a qualifying affidavit, but when she failed to provide one, the court dismissed her claim.

On appeal to the state Supreme Court, Ms. Grier conceded that her nurse expert was not qualified to render an opinion on Mr. Fee's death,

but she maintained that a proximate cause opinion was not required by the state's law. Thus, the plaintiff claimed that the affidavit only needed to include an expert's opinion that the hospital breached the standard of care.[2]

To interpret the tort reform law's affidavit of merit requirement, the South Carolina Supreme Court first looked to the plain language of the statute as the best evidence of what the legislature intended the law to mean.[2] Furthermore, the court presumed the legislative body is "aware of the common law," and when legislators use a "term of art" that has a well-recognized, well-defined meaning in the common law, that they "intended to use the term in that sense."[2,4]

The statutory language of the affidavit of merit mandate states that "an affidavit of an expert witness which must specify at least one *negligent act or omission* claimed to exist and the factual basis for each claim based on the available evidence at the time of the filing of the affidavit."[5]

The court then noted that under the common law,[1] the term "negligent act or omission" consistently has been used to refer *only* to breach and never to causation.[6]

Remember that to establish a cause of action for negligence a plaintiff must prove four elements: 1) a duty of care owed by defendant to plaintiff; 2) *breach of that duty by a negligent act or omission*; 3) resulting in damages to the plaintiff; and 4) that the damages incurred proximately resulted from the breach of duty. Moreover, the South Carolina courts have always held that these are four distinct and separate elements of a negligence claim.[7]

Therefore, the court decided that the phrase "specify at least one negligent act or omission" in the affidavit encompasses only the breach element of a common law negligence claim, and not causation. Consequently, the expert witness completing the South Carolina "affidavit of merit" only needs to state that the defendant breached the standard of care; the expert does not need to also opine on the cause of death or link the breach to the cause of death.

The hospital tried to persuade the Supreme Court that the causation element was "implicitly imposed" by the tort reform law. After all, if a hospital or physician errs, but that error does not cause any damages to the patient, then you don't have a valid lawsuit. The hospital asserted that the expert's opinion must link how the alleged negligence caused the patient harm.

Once again, the court chided the hospital to be mindful of the common law — the maxim that any statute "limiting a claimant's right to bring suit" in derogation of the common law must be strictly construed.[8] In other words, the statute must clearly and unequivocally override the common law or it will not be given effect.

The hospital pressed one of the major goals of the law — to curtail frivolous litigation by ensuring plaintiffs only present legitimate claims. The court agreed that requiring the affidavit to contain an opinion regarding causation furthered that important goal; however, it found no evidence that the legislature unambiguously intended to include the causation link and, therefore, it was confined to what the

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

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

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

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Vice President / Group Publisher: Donald R. Johnston
Executive Editor: Shelly Morrow Mark
Managing Editor: Leslie Hamlin
Physician Editor: Arthur R. Derse, MD, JD, FACEP
Contributing Editors: Robert Bitterman, MD, JD, FACEP, and Stacey Kusterbeck

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Questions & Comments
Please contact **Leslie Hamlin, Managing Editor**, at leslie.hamlin@ahcmedia.com.

statute actually says, not what it ought to say. Accordingly, Ms. Grier was allowed to proceed with her lawsuit against the hospital for the wrongful death of Mr. Fee.

The ruling obviously disappointed physicians practicing in South Carolina. Mr. Todd Atwater, CEO for the South Carolina Medical Association, said after the court ruling that, "It undermines the preliminary [lawsuit] process and the expert witness role in establishing whether the case is legitimate. The process was set up to avoid clogging up the courts and to weed out frivolous cases."[9] Mr. Atwater then added, "We're going to have to go back [to the legislature] and fix it."[9]

Missouri: *Watts v. Cox Medical Centers et al*

Two Missouri Supreme Court cases a couple of months apart demonstrate succinctly the difference between statutory claims and claims originating from the common law.

The first case, *Sanders v. Iftekhar Ahmed, MD,*[10] was a wrongful death lawsuit in which the family claimed the patient's neurologist failed to recognize and treat a fatal side effect resulting from depakote he prescribed to treat her seizures. The jury awarded $9.2 million in non-economic damages, but the court reduced the amount to $1.2 million to comply with the state's then existent cap on non-economic damages.[11] The family appealed, asserting that the state's non-economic damages cap for medical liability cases was unconstitutional for a host of reasons, including violating the right to trial by jury.

The Supreme Court of Missouri noted that a wrongful death claim is a creature of the legislature, a statutory claim, and that Missouri has never recognized a common-law claim for wrongful death.[12,13] Since the claim is not derived from the common law, there is no right to trial by jury and, hence, the damages available are not within the purview of the jury. Moreover, the court said, "To hold otherwise would be to tell the legislature it could not legislate; it could neither create nor negate causes of action and in doing so could not prescribe the measure of damages for the same." Thus, the Supreme Court justices said the state legislature has the power to enact damages caps on statutory causes of action such as wrongful death.[10]

The second case, *Watts v. Cox Medical Centers, et al.*, just decided on July 31, 2012, was much more controversial and, unfortunately, highly detrimental to the larger universe of ordinary medical malpractice claims.[14]

Mrs. Watts' son was born severely brain injured because Cox Medical Centers and its physicians provided negligent health care services. The jury awarded Watts $1.45 million in non-economic damages and $3.371 million in future medical damages. The trial court entered a judgment reducing Watts' non-economic damages to $350,000, as required by the state's cap on non-economic damages.[11,14] Mrs. Watts appealed the case.

The Missouri Supreme Court held that the cap on non-economic damages was unconstitutional because it violated the right to a jury trial. The court determined that personal injury claims for medical negligence were rooted in the common law, and as such, were governed by the section of the state constitution that provides "the right of trial by jury as heretofore enjoyed shall remain inviolate."[14,15]

The phrase "heretofore enjoyed" means that "citizens of Missouri are entitled to a jury trial in all actions to which they would have been entitled to a jury when the Missouri Constitution was adopted" in 1820.[16] Therefore, since Missouri common law entitled a plaintiff to a jury trial on the issue of non-economic damages in a medical negligence action in 1820, Watts has a state constitutional right to a jury trial on her claim for non-economic damages for medical malpractice.

The court held that, like any other type of damages, the amount of non-economic damages is a fact that must be determined by the jury and is subject to the protections of the Constitution's right to trial by jury. Additionally, the right to trial by jury "heretofore enjoyed" was not subject to legislative limits on damages; therefore, the plaintiff's right for the jury to set those damages must remain "from the reach of hostile legislation."[14]

The court also noted that many other states with constitutions like Missouri's, such as Washington, Oregon, Alabama, and Florida, have also concluded that the assessment of damages is a fact-finding function of a jury, and any limit on non-economic damages that restricts the jury's fact-finding role violates the constitutional right to trial by jury.[17-20]

The dissent in the case took umbrage with the

majority usurping the role of the legislature to determine the amount of non-economic damages an injured person can receive in a tort action, stating "whether this is 'good policy' is not a question for this Court." As Chief Justice Roberts noted in the litigation of the Affordable Care Act, courts have "the authority to interpret the law," but "[courts] possess neither the expertise nor the prerogative to make policy judgments. Those decisions are entrusted to our elected leaders. "It is not [a court's] job to protect the people from the consequences of their political choices."[21]

The dissenting justice of the Missouri Supreme Court noted that the majority was overturning the Supreme Court's longstanding (20 years), well-established precedent that the non-economic damages cap does not violate Missouri's constitutional guarantee to a jury trial.[22]

The dissent agreed that the role of the jury is fact-finding, including determining liability and the measure of damages, both economic and non-economic damages. However, it argued that once the jury completes its fact-finding duty, it has completed its constitutional task.[14] It is then the court's duty to apply the law, and it is the legislature that establishes the substantive legal limits of a plaintiff's damage remedy. As such, it is a matter of law, not fact.

Furthermore, the dissent noted that the Missouri Supreme Court has held that "the legislature has the right to abrogate a cause of action cognizable under common law completely," and "if the legislature has the constitutional power to create and abolish causes of action, the legislature also has the power to limit recovery in those causes of action."[22,23] In other words, the right to jury trial does not limit the legislature's authority to determine what the elements of damages shall be.

Additionally, many other states have held that non-economic damages caps do not violate their states' respective constitutional right to a jury trial. These states include Nebraska, Idaho, Ohio, Maryland, Virginia, Alaska, South Carolina, Utah, Kansas, Indiana, Maine, West Virginia, and California.[24]

At least four other states, Florida, Michigan, Mississippi, and Indiana, await pending court decisions on the fate of their caps on non-economic or total damages resulting from medical malpractice liability claims.[25]

Conclusion

Liability reform advocates and legislators must research the common law and understand the impact it can have on the constitutionality of statutory language enacted to curtail frivolous litigation or establish non-economic damages caps. Legislatures, representing the will of the people, should have the discretion to set reasonable limits on the litigation process and the substantive damages available in order to balance the impact on injured parties with the impact on access to affordable, timely, and competent health care services.

In some states, such as Missouri, that understanding and discretion may not be enough to install reasonable tort reforms — it may take amending the state constitution, as was done in Texas to impressive salutary effect.

The tort reform battles will no doubt be enduring. ■

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Missed Timeframes Unexplained? Case May Become Indefensible

Explanation often missing in chart

An EKG revealed a woman's obvious ST-elevation myocardial infarction, but she refused to go to the cardiac catheterization lab before speaking to her husband, who proved difficult to reach by phone.

"We documented clearly that two physicians advised the patient that she needed to go to the cath lab," says **Corey M. Slovis**, MD, professor and chairman of the Department of Emergency Medicine at Vanderbilt University Medical Center in Nashville, TN.

The ED nurses also charted the patient's refusal of diagnostic and therapeutic cardiac catheterization, secondary to her desire to speak with her husband before she went to the lab.

If a bad outcome had occurred and it wasn't clearly documented that the patient caused the delay, then a plaintiff's attorney could have used it against the hospital and emergency physician (EP) to argue that the standard of care was breached, says Slovis.

"The woman had a great outcome, but we did not meet the door-to-balloon time standard," says Slovis. "The chart was exempted from audit, as the reason for delay was clearly documented as not an ED or systems issue but an individual patient preference issue."

Document Justifiable Reason

"The most frustrating thing for someone in leadership is when a good doctor has tried to provide good care and there has been something out of their control but they don't document it in the chart," says Slovis.

If timeframes aren't met in the ED for interventions such as CT scans, administration of t-PA, or angioplasty, and a bad outcome occurs, this can be used by plaintiff attorneys to argue that the standard of care was breached, says Slovis.

"If there is a justifiable reason for a delay — and there often is — it is absolutely essential to document what that reason was," he underscores.

It may be that there was difficulty in obtaining a previous EKG, that the patient's EKG was initially

not believed to be diagnostic, or there was difficulty in making the diagnosis.

If a patient wasn't admitted for pneumonia and antibiotics weren't given in the ED, for instance, Slovis says the EP's charting might read, "The infiltrate was believed due to a noninfectious etiology, and this was discussed with the patient's inpatient team."

"As long as things are documented, then the EP should generally be held harmless," says Slovis. "It's when we fail to document things and there are unexplained lapses in times that we have great exposure."

The chart may not reveal that a patient with suspected acute coronary syndrome didn't receive an EKG within 10 minutes because the EP was unaware he or she was in the waiting room. "That standard is not met, and the EKG is not read in a timely fashion, and it appears that the EP is not doing his or her job adequately," says Slovis.

John Tafuri, MD, FAAEM, regional director of TeamHealth Cleveland (OH) Clinic and chief of staff at Fairview Hospital in Cleveland, says EPs should avoid pointing fingers at others who caused a delay and simply document the facts, such as, "Called the cardiologist at 3 and he arrived at 4," instead of "Waiting for the cardiologist who has still not shown up."

Tafuri says that he commonly sees documentation that omits explanations about why delays occurred. "Physicians may say 'This is typical.' But when a layperson looks at it, he or she may say, 'Why was there a 30 minute delay?'" he says.

Tafuri reviewed a case of a patient with sudden paralysis of his lower extremities, in which the EP immediately recognized the possible spinal cord emergency and ordered an MRI within 10 minutes. "However, the patient's MRI was not completed for almost five hours, with no explanation in the chart. That spiked the plaintiff attorney's interest in the case," he says.

While the fact that a patient arrested is typically well-documented, a patient's initial refusal to go to the cardiac catheterization lab may not be. If this *was* documented in the medical record, however, Tafuri says a plaintiff's attorney would be unlikely to pursue the case even if the patient eventually agreed to go.

"If the patient's refusal delayed calling the cardiologist, that is very important to document," he says. "If the cath lab team is delayed by inclement weather, that is also something that a layperson could understand."

Less Likely to Pursue

Good documentation about the reason for delays makes it less likely that a plaintiff's attorney will agree to pursue a malpractice case in the first place, explains Tafuri, whereas if the chart doesn't contain any information on the reason for delays, the only way to find out why is to file a claim and obtain depositions.

"Even if there is a reasonable explanation at that point, they are more likely to follow through with the case. Once they have invested money in the case, they tend to not want to drop it," he says. "They have more impetus to continue and see if they can get a settlement."

Because attorneys work on a contingency fee basis, any time and money put into a case is lost without settlement or judgment, says **Jennifer L'Hommedieu Stankus**, MD, JD, an emergency physician at Team Health in Tacoma, WA, and physician advisory board member at Medical Protective.

"If a plaintiff's attorney has put *any* significant time and money into a case, they will continue to try to recover their expenses — it's not always about the client," she says. "And they know that if they are persistent and willing to settle, they can often get something for their time."

More Timeframes to Meet

"One of the beauties of emergency medicine is that we have the opportunity to save lives and save limbs, but one of the challenges is to keep up with an ever-increasing number of standards," says Slovis. He points to the American Cardiology Association/American Heart Association's standard of door-to-balloon within 90 minutes, which is endorsed by the American College of Emergency Physicians and the Emergency Nurses Association.

"That is a national standard, and we need to work either to meet it or explain why we didn't," he says. "Other timeframes may not appear to be based on best judgment and best care. Some of us fear we may be inundated with standards but without enough assistance to meet them."

Tafuri cautions against adding to the number of timeframes that need to be met by specifying timeframes in ED policies that aren't set by national organizations, or that the ED can't meet virtually 100% of the time.

"The plaintiff attorneys will go through the entire emergency department policy book.

Anything in that book that you did not meet, they will bring up," he says. "They love to have something in writing that they can hold up and say, 'This is what they had in their own policy and they didn't follow it.'"

Standard of Care Breached?

Failure to meet a timeframe doesn't necessarily mean the standard of care was breached, says Tafuri. "Most juries understand that there are some events that are not preventable," he explains. "If you can document them in the record, it is more likely that a jury will understand the situation and rule for the EP."

The goal is to get everyone to the cath lab in 90 minutes or less, for instance, but it's not necessarily the standard of care for a particular patient because there may be circumstances beyond the EP's control that preclude him or her from meeting the timeframe.

"With any guideline, there are times when people don't meet the guideline. Many times there are explanations for why that is the case," says Tafuri. "If you are widely outside the guideline, or didn't take reasonable steps to try to meet it, that's when you start to get into malpractice."

Although the plaintiff's attorney may not be able to prove that the missed timeframe breached the standard of care, "what it does mean is that the provider is swimming upstream, in terms of the legal battle," says L'Hommedieu Stankus.

"As long as a reasonable provider would have had similar difficulties with the medical decision-making process, your reasoning is well-documented, and nursing notes do not contradict your conclusions, you are in a good position from a legal standpoint," she says. L'Hommedieu Stankus gives these recommendations:

• Document specific physical exam findings and history and why those prevented you from reaching the correct conclusion.

"Cases in which timeframes arise are often due to triaging errors or atypical presentations of a particular problem," she says.

L'Hommedieu Stankus says that in those cases, the EP should clearly identify impediments to making the decision to give antibiotics or call cardiology or neurology.

For example, a pneumonia patient's initially normal chest X-ray may have caused delayed administration of antibiotics, or a patient with very atypical myocardial infarction symptoms may not get an aspirin on arrival and has a delay in door-to-balloon time because he or she wasn't triaged as chest pain.

• Specify the worst possible diagnoses on your differential and explain how these were excluded or why they were not pursued.

"This is the area that is most difficult for emergency medicine physicians because of time considerations and the fact that many of us use T-sheets that have little room for such documentation," says L'Hommedieu Stankus. "It may take a few minutes at the time, but it could save years of litigation stress in the future."

• Document at the time of the decision or at the time that full information is available.

"If it is done after the fact, it may appear to be defensive," she says. "But if you haven't had time and have to go back later, it is better than not doing it at all. It is very difficult to remember the details of all of our patient encounters, particularly months to years after the fact." ■

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For more information, contact:

- Corey M. Slovis, MD, Professor and Chairman, Department of Emergency Medicine, Vanderbilt University Medical Center, Nashville, TN. Phone: (615) 936-1315. E-mail: corey.slovis@Vanderbilt.edu.
- John Tafuri, MD, FAAEM, Regional Director, TeamHealth Cleveland (OH) Clinic. Phone: (216) 476-7312. Fax: (440) 835-3412. E-mail: jotafu@ccf.org.

Inconsistencies in EPs' Ordering of Head CTs

There is significant variation in emergency physicians' ordering of head CT scans for trauma patients, according to a survey of 37 attending EPs conducted during 2009, which quantified their risk tolerance and malpractice fear.[1]

"What this shows is that despite guidelines and best practices, physicians are highly variable in the way they utilize imaging. It certainly begs the question of what is required to decrease the variability," says **Richard D. Zane**, MD, FAAEM, one of the study's authors and chair of the Department

of Emergency Medicine at University of Colorado Hospital in Denver.

"Standards and best practices are widely published; they are just not followed," says Zane. "It's unclear why, but we do know that practice patterns suggest that physicians are not following standard practices for utilization of imaging."

Tools Decrease Variation

Zane says that variability in EPs' ordering of head CT scans can be decreased by embedding decision support tools in electronic medical records and order entry systems, and standardizing guidelines and practices, not only within one ED and hospital but within systems, regions, and even the United States.

"There are so many guidelines that it's impossible to remember every single indication for every study," he says. "Embedded decision supports allows real-time access to those guidelines in a very specific way."

Depending on how the tool is set up, if the EP ordered a diagnostic intervention without meeting the criteria within the guidelines, it would either allow the EP to move forward, ask the EP to enter the reason before moving forward, or not allow the EP to move forward.

"We have had tremendous success with embedded decision supports for ordering chest CTs for PE [pulmonary embolism]," reports Zane.[2]

Variability was decreased after EPs were asked for an explanation if they ordered a CT for PE that didn't meet certain criteria, and given reminders if patients recently had a chest X-ray.

Zane attributes this to a combination of real-time education and the fact that EPs knew their ordering was being watched and that if they were aberrant, their reason would be looked at. "Also, they are somehow being assuaged by the fact that the institution is endorsing the guidelines because they are embedded in the ordering system," he says.

A 2011 survey of 245 members of the Michigan College of Emergency Physicians showed that EPs with a higher fear of malpractice score tended to order more head CT scans in pediatric minor head trauma.[3]

"Despite this trend, our group was surprised that this association was not statistically significant," adds **Andrew Wong**, MD, the study's lead author and associate medical director in the Department of Emergency Medicine at University of California, Irvine Medical Center.

How malpractice risk factors into medical decision-making may be different for other medical conditions, says Wong, noting that other research links malpractice fear with ED decision-making in evaluating patients with possible acute cardiac ischemia.[4]

"You never know why a physician perceives risk," says Zane. "In fact, what people have seen is that there is no single attributable factor that has a physician feeling as though this is a risky encounter." What is unclear is whether the EPs' perception of risk is actually grounded, he adds.

"In general, what prompts patients to sue doctors or hospitals are issues revolving around the doctor-patient relationship," says Wong.[5]

Wong says that the decision to perform a head CT on an ED trauma patient should be based on the clinical context, and not malpractice risk. "There are guidelines, such as the Canadian Head CT Rule, created to help clinicians make those decisions," he notes.

However, malpractice concerns may play into an EP's decision if he or she is put in a situation in which a head CT is not clinically indicated, but the patient or family persists in demanding a head CT. "In this case, the doctor-patient relationship is adversarial, and if an adverse event were to occur, the patient is more likely to sue." he explains. "Under this circumstance, I can see how a physician is inclined to order a head CT." ■

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For more information, contact:

- Andrew Wong, MD, Assistant Clinical Professor of Emergency Medicine/Associate Medical Director, Department of Emergency Medicine, University of California, Irvine School of Medicine. Phone: (714) 456-5239. E-mail: andrew.wong@uci.edu.
- Richard D. Zane, MD, FAAEM, Chair, Department of Emergency Medicine, University of Colorado Hospital, Denver. E-mail: richard.zane@ucdenver.edu.

Apologies: Early Offers Mean Fewer ED Suits

Unfounded claims aren't settled, however

When a teenage patient presented to the ED at University of Michigan Health System (UMHS) in Ann Arbor with unexplained pain in her thigh, the emergency physician (EP) did all the appropriate things to make her comfortable, stabilize the situation, and get her a referral quickly to other specialists, but did not arrive at a definitive diagnosis.

After the orthopedic surgeon and sports medicine physician both missed sarcoma and the patient had her leg amputated, the patient's family threatened to name the EP along with the other physicians in the ensuing lawsuit.

"Being careful not to criticize the others, we met with the parents, the patient, and their lawyer," says **Richard C. Boothman**, the organization's chief risk officer. At first, the patient's father angrily blamed the EP for "starting the ball rolling in the wrong direction," and missing an opportunity to make a diagnosis as quickly as possible.

The EPs involved and UMHS risk managers carefully explained the role that emergency medicine plays in health care, and why the expectation isn't that the EP will always get a definitive diagnosis.

"The family was ultimately moved by our lack of defensiveness and our willingness to listen to the horrors of a bright, active teenager losing her leg," he says. "Our doctors' willingness to express their own sadness at the outcome, without feeling the need to be guarded on a human level, were important components to that conversation."

The EP's obvious empathy for the patient and family, even in the face of the initial hostility and accusations, "really made all the difference," says Boothman. "Our emergency medicine doctors were not included in the ensuing lawsuit. Interestingly, the other doctors were cross-examined at trial about their refusal to meet the family like we did."

Savings from Early Settlements

Average litigation costs for ED malpractice cases are approximately $105,000, compared to average settlement costs of $60,000, reports Boothman. "Settling meritorious cases proactively, without the need for litigation, saves a lot of money," he says. "We incur far less cost, of course, with no attorneys' fees on our part."

Since UMHS' error disclosure program began in 2001, average monthly costs have decreased for total liability, patient compensation, and non-compensation-related legal costs.[1,2]

With early settlements, plaintiff's lawyers haven't run up exorbitant costs, and may reduce their fees if they don't have to litigate, adds Boothman. "There is a time value and no risk to a settlement that makes both litigants and lawyers willing to take less early," he says.

"Medically Dishonest" Claims

Boothman says that the organization occasionally sees "medically dishonest" ED claims, which aren't settled even for amounts considered to be "nuisance value." For instance, patients sometimes threaten to sue EPs for failing to order head CT scans for children who present with a relatively mild head trauma.

"We know now that close clinical monitoring is as good as a CT scan for a child who took a tumble off his or her bike, in the surveillance for a possible subdural hematoma," says Boothman.

Boothman says lawsuits have been avoided with non-meritorious cases like this after the EP explains upfront what happened and why *before* anyone has invested money in litigation.

"Occasionally over the years, we've been forced to defend and litigate emergency medicine cases that were supported by dishonest experts willing to testify for the patient," he adds. "Most seem to be situations in which an 'expert' tries to attach more responsibility to the ED than is justified."

One such case involved the death of a patient who presented with chest pain and shortness of breath, who fell at home as he was putting up Christmas lights and fractured ribs and his skull. He was admitted and three days later, as nurses were ambulating him, he suddenly collapsed and died from a massive pulmonary embolus (PE).

"The patient's daughter was a physician, and one of the most unreasonable, hostile family members we've ever tried to reason with," says Boothman. The claim was that the EP should have worked the man up for a PE, despite having a clear basis for his chest pain and shortness of breath.

An EP expert for the plaintiff testified that it is incumbent on EPs to rule out the most life-threatening diagnosis among the differential diagnoses first, no matter how implausible it seems at the time and no matter what the other evidence shows.

"He said that we should 'assume PE unless proven otherwise,' and that Doppler testing and a spiral CT should have been done," says Boothman. "We felt the claim was completely unjustified, and the expert's criticisms a dishonest depiction of what most emergency medicine physicians would have done under the circumstances."

The case did proceed to litigation, and was settled for a very modest amount of money based on some nursing issues involved in the man's inpatient care, he reports.

Patients Given Context

Boothman says that in his experience, EPs are skilled at making patients feel like they've bonded with the doctor, even when the actual interaction is relatively brief. "To make a patient feel like he or she is the only person who matters at that interaction, no matter how busy the ED is at that point in time, is a gift that many excellent ED physicians have," he says. "And it makes a huge difference when something goes wrong."

Boothman says that context is important when UMHS EPs disclose an error to the patient. They explain what they were worried about at the time, the pros and cons of every alternative to care or differential diagnosis, why they chose the path they did, and why it seemed reasonable under the circumstances.

"These are all important factors in doing a disclosure, and even more important in emergency medicine circumstances," he says. "Just telling a patient, 'Sorry, we blew it,' without context, does more harm than good."

EPs don't say anything to the patient that they are not prepared to say in public, or even in a courtroom, adds Boothman.

"We view this as a process, not a single conversation, and almost never a conversation that occurs in the heat of the moment," he says. "Few cases turn out as they first appeared. We always take time to investigate before committing ourselves one way or the other." ■

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For more information, contact:

- Richard C. Boothman, Chief Risk Officer, University of Michigan Health System, Ann Arbor. Phone: (734) 764-4188. E-mail: boothman@med.umich.edu.

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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. ■

CME/CNE 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. ■

CME/CNE QUESTIONS

1. Which is recommended for documentation involving failure to meet timeframes for interventions in the ED, according to **Corey M. Slovis**, MD?
   A. Reasons for delays should not be documented by the EP unless there was difficulty in making the diagnosis.
   B. If there is a justifiable reason for a delay, it is absolutely essential for the EP to document what that reason was.
   C. It is not advisable to give any specifics regarding a patient's initial refusal of care.
   D. The EP should omit explanations as to why delays occurred, unless these involve a specialist's failure to come to the ED in a timely manner.

2. Which is true regarding the standard of care and time-specific ED interventions, according to Slovis?
   A. If timeframes aren't met in the ED for time-dependent interventions, this can be used by plaintiff attorneys to argue that the standard of care was breached.
   B. Plaintiff attorneys generally cannot utilize missed timeframes to argue that the standard of care was breached.
   C. Any failure to meet timeframes specified by the ED's own policies means the standard of care was breached.
   D. Missed timeframes are considered as a violation of the standard of care for all ED patients, regardless of if there were circumstances beyond the EP's control that precluded him or her from meeting the timeframe.

3. Which is true regarding variation in emergency physicians' (EPs) ordering of head CT scans in trauma patients, according to **Richard D. Zane**, MD, FAAEM?
   A. Physicians are highly variable in the way they utilize imaging because of a lack of published guidelines and best practices.

B. Real-time access to guidelines has been shown to have no effect on EPs' following standardized practices for utilization of imaging.
C. There is significant variation in emergency physicians' ordering of head CT scans for trauma patients.
D. Variability in EPs' practice is increased by embedding decision support tools in electronic medical records and order entry systems.