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Wisconsin Court Rules On-call Physician with Privileges is an 'Employee' of the Hospital for Purposes of EMTALA Whistleblower Enforcement

By Robert A. Bitterman, MD, JD, FACEP
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Two years ago, a Texas court, in the case of *Dr. Zawislak v. Memorial Hermann Hospital*, determined that emergency physicians were "employees" of the hospital for determining whether they could sue the hospital under the Emergency Medical Treatment and Labor Act's (EMTALA) whistleblower provision for retaliatory termination (see the February 2012 *ED Legal Letter*).[1,2] Now, a federal district court in Wisconsin has expanded on the Zawislak decision to include on-call physicians as "employees" of the hospital, allowing them to sue the hospital for allegedly terminating their privileges for reporting violations of EMTALA.[3]

The Case of *Dr. Muzaffar v. Aurora Health Care Southern Lakes Inc.*

The Facts. Dr. Muzaffar was on call for internal medicine at Lakeland Hospital in Aurora, WI, when asked to accept a patient in transfer to Aurora. He refused to accept the transfer, claiming the patient would receive better care at a different hospital. However, the transferring physician did not agree and somehow finagled the patient's transfer to Aurora without Dr. Muzaffar's authorization. Additionally, two other patients were transferred to Aurora the same day onto Dr. Muzaffar's service without his knowledge or consent. Dr. Muzaffar claimed he

would have refused to authorize these two transfers because the transferring physician failed to complete legally mandated transfer documentation in compliance with EMTALA. Subsequently, he reported the supposed EMTALA violations to the hospital's Medical Executive Committee.[3]

Not long afterward, Dr. Muzaffar alleged that Aurora retaliated against him by rescinding his medical staff privileges for reporting that the transfers violated EMTALA. The hospital claimed it released him for reasons related to interpersonal difficulties or disruptive behavior.[3]

The issue before the court was whether an on-call physician who enjoys privileges at a hospital is an employee of that hospital for purposes of EMTALA's whistleblower provision.[3,4]

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Arguments of the Parties

The physician argued that his relationship with Aurora was governed by the hospital's Medical Staff Bylaws, which required him to perform certain functions, including "providing on-call coverage for emergency care services within his clinical specialty."[3] Dr. Muzaffar asserted that his schedule for on-call duties was set by Aurora and it was while he was actually on call at Aurora that he "observed what he believed to be EMTALA violations." Additionally, he told the court that when performing his on-call duties, he "directly and personally provided medical evaluation and treatment to Aurora's emergency room patients" and was "personally responsible for making decisions regarding stabilizing and transferring patients and conforming to EMTALA in handling the patients."[3]

Furthermore, relying on the Zawislak decision, Dr. Muzaffar basically made a public-policy argument, stating that finding he is not an employee of Aurora for enforcement of EMTALA would contravene the purposes of the statute.[3,5]

Aurora did not contest Dr. Muzaffar's statements regarding his medical staff on-call responsibilities, arguing instead that his on-call services were a condition of privileging rather than a condition of employment. Aurora stated it did not compensate Dr. Muzaffar in any way; did not provide him with employment benefits; did not pay his malpractice premiums; did not provide him with office space; did not bill his patients; did not pay his income or social security taxes; and did not provide him with paid vacation. In other words, Dr. Muzaffar was not its employee in the traditional sense of an IRS W-2 hospital employee. Moreover, Aurora claimed that any and all physicians it employs are required to enter into a written "Physician Employment Agreement" with the hospital, which Dr. Muzaffar had not done.[3]

Aurora countered Dr. Muzaffar's public-policy argument by arguing that the court should use Title VII employment discrimination law to determine if an individual is an employee for purposes of EMTALA's whistleblower protection. (Most courts use Title VII analysis to decide retaliation claims under other non-EMTALA federal statutes.)

Specifically, Aurora argued that under court precedent, a physician with staff privileges is not an employee but rather an independent contractor for purposes of bringing employment discrimination claims.[6] Aurora further argued that Title VII law should apply "because at least one federal district court in the case of *Elkharwily v. Mayo Clinic Health System* has held that 'courts examine EMTALA-retaliation claims under Title VII jurisprudence.'"[7]

The Court's Decision

The court noted that the purpose of EMTALA is to prevent "patient dumping," the practice of refusing to provide emergency medical treatment to patients who are unable to pay, or transferring them before their emergency conditions are stabilized.[3,8]

The law provides a private right of action for individuals who sustain personal harm as result of a hospital's violation of the statute,[9] and it also contains a whistleblower provision in order "to ensure that persons are not penalized or retaliated against for reporting violations of EMTALA's terms."[10,11] The relevant portion reads:

Whistleblower protections. "A participating hospital may not penalize or take adverse action against 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."[10]

The whistleblower provision, therefore, protects physicians in only two circumstances: (1) if the physician refuses to authorize a transfer of a patient who has not been stabilized;[12] and (2) if the physician is a hospital employee who reports violations of EMTALA.

Dr. Muzaffar clearly did not fall within the first category of protected physicians, and EMTALA itself and The Centers for Medicare and Medicaid Services EMTALA regulations do not define the meaning of the term "employee" as used in the statute.[13] Thus, the dispute concerned whether Dr. Muzaffar was a hospital employee for purposes of EMTALA's whistleblower provision.

The court noted that the Title VII cases on which Aurora relied were not germane to the EMTALA issue. First, there was no 7th Circuit precedent applying Title VII analysis to the definition of employee under EMTALA's whistleblower protection. Rather, the Title VII analysis was used to determine the type of evidence needed to show retaliation, not whether the physician was an employee of the hospital under the whistleblower provision.[3] In fact, in the case specifically cited by Aurora, *Elkharwily v. Mayo Clinic*, there was no dispute as to the employer-employee relationship — the physician plaintiff was an employed hospitalist under contract with the defendant.[14]

The Elkharwily case is highly relevant to alleged EMTALA violations arising out of the emergency department in another way. The court expressly ruled that failure of a hospital's on-call physician to come to the ED when requested by the treating physician is a violation of EMTALA; and reporting failure of the on-call physician to respond appropriately by a physician with hospital privileges or any other hospital employee is an act protected by the EMTALA whistleblower provision.[14]

Second, it makes sense that a physician with staff privileges is not an employee but rather an independent contractor for purposes of bringing an employment discrimination suit under Title VII, because an employer cannot prevent discrimination against an employee or in a workplace it does not control. The court judged that if EMTALA's whistleblower provision's purpose was the protection of employees from workplace discrimination, the Title VII independent contractor analysis would be helpful in defining an employee under the whistleblower provision. However, that is not the case: EMTALA's purpose is to prevent patient dumping, and the whistleblower provision enforces that purpose.[3]

After considering the arguments of the parties and available court precedent, the court accepted the reasoning behind the Zawislak case in Texas.[3] Dr. Zawislak was an emergency physician who alleged that his medical staff privileges were revoked after he reported two EMTALA violations he observed at the hospital where he had privileges.[1,2] The Zawislak court found that the purposes of EMTALA would be frustrated if a physician who enjoyed staff privileges was not considered an employee for purposes of whistleblower protection. In the words of the court:

"The court does not agree that, because the act affirmatively prohibits hospitals from taking adverse action against 'any hospital employee,' it impliedly permits hospitals to take adverse action against physicians with hospital privileges who have observed and reported EMTALA violations. Such a result would seem to contradict the very purpose of EMTALA. The legislative purpose of the statute is best served by construing it to prohibit participating hospitals from penalizing physicians with medical privileges ... A physician with medical privileges in a hospital's emergency room is in an advantageous position to observe whether a hospital is encouraging and instructing physicians to dump patients."[1]

Aurora tried to argue that Zawislak's reasoning should not apply because, unlike Zawislak, Dr. Muzaffar did not observe violations at the hospital where he had privileges; instead, the alleged violations were by a transferring hospital. The court found this to be "a distinction without a difference." "A privileged physician is in an 'advantageous position' to observe potential EMTALA violations committed by both the hospital where he has staff privileges and by hospitals transferring to the hospital where he has staff privileges. Thus, the purpose of EMTALA — to prevent patient dumping — is achieved whether the reporting physician is privileged at the hospital receiving the patient or the hospital transferring the patient."[3]

Therefore, the court ruled that Dr. Muzaffar was an "employee" for purposes of filing a claim for retaliatory termination under EMTALA's whistleblower provision.[3]

Comment

In its decision, the court noted that the "federal government cannot be in all emergency hospitals at all times."[3] While it may feel as if the government hovers over the ED at all times, there is no question that physicians who actually work in the ED are in the best position to observe and report EMTALA violations. If hospitals were allowed to penalize physicians with impunity for reporting EMTALA transgressions because they were not employed by the hospital in the "traditional" sense, it would have a chilling effect on physician reporting and subvert the purpose of the whistleblower provision of the statute.

The net effect of the court decisions in Muzaffar and Zawislak is to allow physicians to sue hospitals for damages if the hospital takes retaliatory action against the physicians for reporting EMTALA violations that often cause serious harm to the patients involved.[15] ■

REFERENCES.

1. *Zawislak v. Memorial Hermann Hosp. Sys.*, 2011 WL 5082422 (S.D. Tex. Oct. 26, 2011).
2. Bitterman RA. Texas emergency physician sues hospital in EMTALA whistleblower claim. *ED Legal Letter* 2012;23(2):13-17.
3. *Muzaffar v. Aurora HC Southern Lakes Inc.*, No. 13-CV-744 (E.D. Wis. Nov. 27, 2013).
4. *Muzaffar v. Aurora Health Care Southern Lakes Inc.*, No. 13-CV-744 (E.D. Wis. Oct. 4, 2013). The court's initial ruling allowing the physician to argue whether he was in fact an "employee" for purposes of EMTALA.
5. Dr. Zawislak ultimately lost his case due to failure to file the actual EMTALA claim within the law's 2-year statute of limitations. See *Zawislak v. Memorial Hermann Hosp. Sys.*, No. H-12-2970 (S.D. Tex. April 3, 2013).
6. See *Alexander v. Rush North Shore Medical Center*, 101 F.3d 487 (7th Cir. 1996) (applying the common law agency test to determine whether a physician with staff privileges was an employee or independent contractor for purposes of bringing a Title VII employment discrimination claim and finding he was an independent contractor); and *Vakharia v. Swedish Covenant Hosp.*, 190 F.3d 799 (7th Cir. 1999) (finding that an anesthesiologist was an independent contractor and could not bring a Title VII employment discrimination claim).
7. *Muzaffar v. Aurora HC Southern Lakes Inc.*, No. 13-CV-744 (E.D. Wis. Nov. 27, 2013) citing *Elkharwily v. Mayo Holding Company*, No. 12-3062, 2013 WL 3338731 (D. Minn. Jul. 2, 2013).
8. See *Beller v. Health and Hosp. Corp. of Marion County*, 703 F.3d 388 (7th Cir. 2012).
9. 42 U.S.C. 1395dd(d)(2)(A).
10. 42 U.S.C. 1395dd(i).
11. Quoting O'*Connor v. Jordan Hospital*, No. 10-11416-MBB, 2013 WL 3105647 (D. Mass. Jun. 17, 2013).
12. See for example, *Ritten v. Lapeer Regional Medical Center*, 611 F.Supp.2d 696 (E.D. Mich. 2009), where a Michigan obstetrician 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.

13. 42 C.F.R. 489.24 et seq.
14. *Elkharwily v. Mayo Holding Company*, No. 12-3062, 2013 WL 3338731 (D. Minn. Jul. 2, 2013). See also *O'Connor v. Jordan Hospital*, No. 10-11416-MBB, 2013 WL 3105647 (D. Mass. Jun. 17, 2013): Ms. O'Connor was employed as a nurse at the defendant hospital.
15. The damages available under any 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. 42 U.S.C. 1395dd(d)(2)(A).

EPs Can Protect Themselves Legally From 'Problem' Patients

Careful charting makes claims defensible

An inebriated frequent emergency department (ED) patient, discharged after a cursory examination and no treatment, was found dead in the hospital's parking lot a few hours later. "A more thorough examination might have discovered evidence of an impending myocardial infarction," says **Dan Groszkruger**, JD, MPH, principal of Solana Beach, CA-based rskmgmt.inc.

The surviving family members sued for wrongful death based on negligent failure to diagnose and treat the patient's heart attack. "The cursory nature of the examination and lack of treatment harmed the ED's defense," says Groszkruger.

While some frequent ED patients are "annoying, manipulative, and even sophisticated in how they access ED services," says Groszkruger, they do not represent a population any more likely to sue EPs than other ED patients.

"These patients are more likely to threaten litigation compared to other patients. But in my experience, the threats always were 'hollow' and did not lead to actual lawsuits," he adds. Below are some "problem" patients that pose unique liability risks for EPs:

• Patients suspected of drug-seeking.

"With a 'drug-seeker' patient, EPs hear complaints and a history of symptoms or problems which normally would justify narcotics," says Groszkruger.

If the EP suspects that such complaints are false or exaggerated, says Groszkruger, "only diligent recognition and documentation of physical exam findings and test results, inconsistent with claimed symptoms, will justify a refusal to prescribe narcotics or proposing alternate modes of treatment not including pain killers."

If the patient states that her headache is "excruciating," and reports it as a 9 on a scale of 1 to 10, how might a skeptical EP challenge such symptoms in his or her documentation? "One way is to record observations which are inconsistent with the claimed level of pain," says Groszkruger.

EPs are not required merely to take the patient's word for their pain level, if other factors cast doubt on the legitimacy of the complaint, he adds. "Clinicians are put in a tough spot if they choose not to treat a complaint of severe pain, based only on a 'hunch' or their dislike for the patient," he says.

Thus, says Groszkruger, the EP's documentation should describe any factors that are inconsistent with the patient's claimed pain level — for example, the 'excruciating headache' patient frequently steps outside to smoke a cigarette.

EPs generally are wary about recording chart notes that reveal skepticism about their patient's veracity, adds Groszkruger. "Such doubts make clinicians uncomfortable, because having doubts may appear inconsistent with a genuine interest in treating an ED patient or controlling pain," he says.

However, says Groszkruger, "experts generally suggest that objective charting that accurately describes behaviors and actions, rather than suspicions, theories, or conjecture, is a best practice."

Groszkruger advises that "truth is the best defense" when a skeptical EP is hesitant to administer pain killers to a suspected drug-seeker. One example that he observed was a young patient chatting on her cell phone who suddenly grabbed her head and began loudly complaining of excruciating headache when the EP arrived.

"I suppose it is possible that her pain was not as severe while she was chatting on her cell phone. But documenting her behavior minutes before her pain complaints should at least raise a question regarding her veracity," he says.

• Psychiatric patients, or those who display irrational behaviors triggered by panic, fear, anxiety, or brain trauma.

"None of these are likely to sue more frequently than an average ED patient, to my knowledge," says Groszkruger.

Patients with multi-system medical and psychological issues are most likely to be unsatisfied with the results of medical intervention, however, says **Joan Cerniglia-Lowensen**, JD, an attorney at Pessin Katz Law in Towson, MD.

"Unhappy patients are much more likely to file a lawsuit against an emergency provider with whom they have a brief relationship," she says.

• Hyper-aggressive personalities.

Remaining calm in the face of provocation is always a good idea, says Groszkruger, and may decrease the chance of a premature action or decision that is not in the patient's best interests, provoked by mere impatience or frustration.

"Aggressive individuals are known to threaten legal action, but only rarely do they follow through on such threats," he adds.

Some patients tell the EP that they are unhappy and intend to sue. "Under that circumstance, the EP should be extremely careful to provide adequate documentation," says Cerniglia-Lowensen.

The exact words of the patient, both in providing history and in their response to treatment, should be utilized whenever possible, she advises.

An example would be a patient with a history of polypharmacy who is seeking additional medications and threatens to sue the EP for refusing to prescribe these. "Additionally, these are the patients with whom the EP should spend more, not less, time communicating the recommended treatment plan," says Cerniglia-Lowensen.

• Patients concealing hidden agendas.

For a variety of reasons, some ED patients volunteer false information or provide "selective" histories, complicating accurate diagnosis and treatment. "Again, such patients are not commonly perceived as likely to pursue medical malpractice litigation," Groszkruger says.

Groszkruger says a rare but known risk is a patient who visits the ED with litigation in mind. "I have heard of disability rights attorneys sending patients to 'set up' a hospital ED for a lawsuit based on ADA [Americans with Disabilities Act] shortcomings. For instance, the ED might lack handicapped access, or facilities that are not wheelchair accessible.

"Theoretically, class action lawyers could steer patients to EDs with an expectation of discovering EMTALA violations," he says.

Groszkruger advises EPs to educate ED personnel about how to deal with their most likely category of "difficult" patients. "Specific EDs generally know what type of 'difficulties' they are likely to encounter, and should prepare accordingly," he says. For instance, most urban EDs frequently encounter drug-seekers as compared to suburban or rural EDs, which are more likely to encounter an occasional mental health or violent patient.

• Patients who fail to follow up.

When an EP reviewed past medical records of a patient presenting with an upper respiratory infection, she discovered that this same patient presented on four previous occasions with extremely elevated hypertension.

"On each occasion, the patient indicated that she would follow up with her primary care provider," says Cerniglia-Lowensen. "There was no evidence that this follow up had ever occurred."

The EP didn't believe admission to the hospital was necessary and, once again, attempted to educate the patient regarding hypertension, but no provider follow-up occurred. Approximately 30 days later, the patient suffered a massive cerebral vascular accident and filed suit against the EP.

"The cause of action presented by a very debilitated patient was that the provider should have known that follow up had not occurred in the past, and was most likely not going to occur under these circumstances," says Cerniglia-Lowensen.

The case was settled before trial because of the EP's inadequate documentation. "I would have liked to have seen a note indicating that the provider discussed with the patient her past failure to follow up, the risks of inaction, and the fact that the provider gave the patient potential providers for follow-up care," says Cerniglia-Lowensen. ■

Sources

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Legal Risks for EPs Who Fail to Obtain a Consult

Failure to obtain specialist consultation is one of the main recurring themes **Ken Zafren**, MD, FAAEM, FACEP, has seen over the years in reviewing medical malpractice claims against emergency physicians (EPs) as an expert witness.

"If the EP is in over his or her head and doesn't realize it, that's a recipe for disaster," says Zafren, emergency programs medical director for the state of Alaska and clinical associate professor in the Division of Emergency Medicine at Stanford (CA) University Medical Center. Here are some actual malpractice cases alleging the EP's failure to obtain specialist consultation:

• A young man was seen in the emergency department (ED) for a red, swollen, painful penis, and the physician's assistant prescribed treatment for a sexually transmitted infection and referred the patient to a county clinic. The patient failed to improve, and several days later, presented to the ED with Fournier's gangrene of the penis.

The physician's assistant should have consulted a urologist for this presentation, which was very atypical for a sexually transmitted infection, but quite typical for a bladder stone unable to pass the urethra, according to Zafren.

"This was a rare diagnosis, but one which the urologist would likely have been able to make and to have managed before the cellulitis progressed to gangrene," he explains. The patient required extensive debridement and reconstructive surgery, and the case was settled.

• An EP ordered a CT scan with IV contrast for a middle-aged man with abdominal pain. The IV dye extravasated into the patient's wrist and hand, causing extreme pain and swelling of the hand.

"Although the pain was not relieved by a large dose of intramuscular opiate medication, the EP told the patient the pain would get better in a few hours and sent him home," says Zafren.

The patient returned a few hours later due to worsening pain, and was immediately diagnosed by a second EP with a compartment syndrome. The patient underwent emergency fasciotomy by a hand specialist.

"In the meanwhile, the abdominal pain resolved without treatment. The plaintiff prevailed against the EP at trial," says Zafren.[1]

• A patient presented with a fever and very painful left prosthetic hip.

"The EP managed to diagnose pyelonephritis as the cause of the fever and hip pain," says Zafren. "The case was subsequently mismanaged by two hospitalists. The patient died from septic shock with multi-organ system failure."

One option for the EP in this case would have been to consult an orthopedic surgeon, who might have suggested imaging or performed a diagnostic arthrocentesis. "There was a huge effusion that was almost certainly present on the first visit. An ultrasound or CT of the hip would have shown the effusion," says Zafren.

• A middle-aged man presented with a chronic large umbilical hernia that he had been planning to have repaired eventually.

"He presented to an ED with the hernia bulging out and very painful," says Zafren. The man had signs of small bowel obstruction, and the overlying skin was purple, indicating ischemic bowel. The EP recognized that the patient had a small bowel obstruction, and proceeded to attempt to reduce the hernia.

"It was the middle of the night," says Zafren. "She testified at deposition that she didn't call the surgeon because all the surgeon would have done would have been to attempt to reduce the hernia." At trial, accounts differed about her technique and the amount of pain this caused the patient, who was discharged home from the ED.

"He returned several hours later in extremis, septic, and with the hernia not reduced. He did not survive the emergency surgery, at which he was found to have a long section of dead bowel," says Zafren.

Zafren says that a surgeon might have attempted to reduce the hernia in the ED, but would most likely have recognized the strangulated hernia and taken the patient to the OR emergently to prevent bowel necrosis.

The EP had already been disciplined by the state medical board for the incident prior to the trial. In his report, the emergency medicine expert for the medical board quoted Tintinalli's emergency medicine textbook regarding the dangers of attempting to reduce a strangulated hernia.

"In fact, it is very unlikely that the EP reduced the hernia, which remained strangulated, causing continuing bowel ischemia," says Zafren. "The case was settled."

Risk-reducing approaches

If the EP needs specialist consultation to manage a patient effectively, the EP should consult the appropriate specialist, underscores Zafren, and failure to do so could result in a successful lawsuit against the EP.

One indication for calling a plastic surgeon to close a wound on the face would be that the patient wants the closure done by a plastic surgeon. "If there is a bad result, or even a perceived bad result, it is conceivable that the patient would sue the EP and the plastic surgeon," says Zafren. "But more likely, the EP would not be sued or would be dropped."

In order to prevail, the plaintiff must prove that the EP managed the case incorrectly, adds Zafren. If an EP is reasonably sure that a patient with abdominal pain does not have a surgical abdomen, the EP can send the patient home with appropriately close follow up and indications to return to the ED. "If the EP isn't sure, the EP should consult a surgeon," he says.

If a patient is seen early in the course of a surgical condition, such as appendicitis, the diagnosis may not be clear yet. "It is common practice to discharge a patient that might have a very early appendicitis with scheduled close follow up in the ED or with the patient's own physician after several hours, with the warning to return to the ED if the pain is not well-controlled or worsens," says Zafren. ■

REFERENCE

1. *Figueroa v. Highline Medical Center et al*. Superior Court of King County, WA. No. 08-2-43576-8 KNT.

Sources

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"If the EP Had Only Told Me" Is Consultant's Likely Defense

"If the EP had only told me, I would have come right in and admitted the patient," is what a consultant is almost certain to claim if named in a lawsuit resulting from a bad outcome that occurred after a patient was discharged from the ED.

In addition to claiming that the EP did not accurately convey the severity of the patient's condition, the consultant might also claim no physician-patient relationship existed.

"The EP would likely still be liable if the consultant gave advice with which the EP disagreed," adds **Ken Zafren**, MD, FAAEM, FACEP, FAWM, emergency programs medical director for the state of Alaska and clinical associate professor in the Division of Emergency Medicine at Stanford (CA) University Medical Center.

For example, the EP would likely be liable for sending a patient home when the EP believes a patient should be admitted, even if the consultant wants to send the patient home without having seen the patient.

"Unless the consultant can convince the EP by telephone that outpatient management would be safe, the consultant should see the patient and discharge or admit based on the consultant's examination," emphasizes Zafren. "If the consultant hasn't seen the patient, the EP would be liable."

If there is a disagreement, the EP is not obligated to discharge the patient, underscores Zafren. "Actions speak louder than words, and the best reaction to a consultant's advice with which the EP disagrees is to hold, admit, or transfer the patient," he says. "The EP remains in charge until the patient is admitted by the consultant."

At that point, the EP's liability is minimized, says Zafren, assuming that the patient was admitted to the correct consultant.

The best way to make claims based on the consultant's recommendations more defensible is thorough documentation, says Zafren. This should include what the EP told the consultant and what the consultant told the EP. "This is especially important when the consultant refuses to come to the ED to examine the patient," he says.

Don't document rants

John Burton, MD, chair of the Department of Emergency Medicine at Carilion Clinic in Roanoke, VA, has reviewed several charts in which the EP gave too much detail about a heated discussion with an admitting physician regarding a patient's admission. "It may have indeed occurred, but it just looks bad in the chart," he says.

For example, if the admitting physician refuses to admit a patient and, in the course of the discussion, launches into an extensive rant about Obamacare, payer status, revenue, and how the future of health care is abysmal, then the record does not need to document the rant.

"Rather, a simple notation stating in the record that the physician refused to admit the patient, citing payer status as an issue, would suffice," says Burton.

Burton says that pursuing unprofessional behavior, such as the fact that the consultant shouted expletives, should be directed to the local medical staff office and not detailed in the record.

"However, sometimes there just is not an alternative to documenting a difficult interaction," he says. "When this is the case, then at least let the other provider know that you will be documenting this in the record."

Burton says that EPs should state this matter-of-factly, without the implication that it is a threat to the other physician.

For example, if the EP calls a physician about a patient who the EP feels strongly should be admitted, but after discussion or evaluation of the patient, the admitting physician "refuses" to admit the patient, the EP will want to document that he thought the admission should be undertaken and that the admitting physician disagreed.

Before placing this documentation in the chart, however, it is prudent for the EP to tell the admitting physician that he or she disagrees and will document in the record that the EP thought the patient's best interests would be served by admission.

The EP need not enter an extensive argument or rationale for his or her own opinion in the record, says Burton, and should simply state the opinion.

"Oftentimes, once the consultant understands that the documentation will reflect the actual events and opposing positions, they will retreat to the more conservative treatment option; in this case, admission," says Burton.

At times, EPs not only don't get the help they seek from a disagreeable admitting doctor, but EPs are also treated condescendingly. In these cases, says **Pete Steckl**, MD, FACEP, director of risk management at EmergiNet in Atlanta, GA, "the atmosphere is ripe for taking out your frustrations by documenting the conversation in an accusatory or unprofessional manner."

It is tempting for EPs to believe they are covering themselves legally by documenting a breach in conduct on the part of the consultant, but in actuality, this can place the EP in legal jeopardy, says Steckl. "Pointing fingers serves only one party. That is the plaintiff's lawyer who, when he sees smoke, just redoubles his search for fire," he says.

Should the admitting physician's care come into question as a result of legal action, all care received by the patient will be scrutinized. "Should there appear a lapse in management, you could find yourself involved in the lawsuit you were attempting to avoid," says Steckl.

Steckl says that EPs should document the discussion in a dispassionate, "just the facts" way

and do what is necessary to get the patient the care that he or she needs.

"Should your grievance with the medical staff member rise to a high enough level, discuss with your facility's medical director the possibility of filing a separate formal complaint through an 'incident report' type of mechanism," he advises. ■

Sources

For more information, contact:

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Medical/Malpractice Claims: Patient's ED Course Was Unclear to Admitting MD

Suits unlikely when direct communication occurs

Lack of appropriate documentation about what occurred in the ED is a common issue in malpractice claims naming both the emergency physician (EP) and the admitting physician, according to **David P. Sousa**, JD, senior vice president and general counsel at Medical Mutual Insurance Company of North Carolina in Raleigh.

"There is not a clear pathway to make sure that continuity of care occurs between that which was started in the ED and that which must continue in the hands of the admitting doctor, such that the admitting doctor doesn't have sufficient information from which to work," he says.

Labs ordered in the ED might come back after the patient was admitted. In this case, Sousa says EPs should call the admitting physician directly to be sure he or she saw the results, particularly if there was a significant positive finding.

"The better and more complete the record, the less likely it is that the EP would ever be named in the suit, or even if they are, that they are going to stay in the case very long," says Sousa.

"Failsafe" system needed

Notably, Sousa says that he almost never sees cases in which a specialist actually comes to the ED, where both the EP and the specialist are directly involved in the patient's care. "I believe the reason for that is when they are both there, there is a greatly reduced chance of a problem in communication or a problem in both having access to the full record," says Sousa.

In contrast, Sousa routinely sees malpractice cases in which the admitting physician lacked information about the patient's ED course. One such case involved a patient who came to the ED and reported a family history of myocardial infarction and complained of exertional chest pain.

Although both findings were recorded by the triage nurse, neither was recorded by the EP as part of his recorded patient history. "The patient is admitted for cardiac monitoring but arrests and cannot be resuscitated," says Sousa. The cardiologist indicated that his care would have proceeded differently had the significant history findings been made clear by the EP. The case was settled before trial at mediation.

In another case, the patient was seen in the ED after a motor vehicle accident with complaints of abdominal trauma in addition to other injuries. An abdominal CT was positive for free air and possible intra-abdominal tears.

The CT results were relayed to the ED after the patient was admitted under the service of a hospitalist. "Nobody from the ED reported the CT results to the admitting physician," says Sousa. "The patient ultimately died from sepsis secondary to seatbelt syndrome evident on the CT."

Sousa says that if both the EPs and the admitting physicians use the same EHR [electronic health record], "that can go a long way toward mitigating this problem." In some hospitals, however, the EHR used by the ED isn't integrated with the EHR used by the admitting physician.

"EPs need to make sure there is a mechanism for getting the whole ED record into the hands of the admitting physician, and also have a 'failsafe' system for ensuring that lab or radiological studies get to the admitting physician," says Sousa. ■

CNE/CME OBJECTIVES

After completing this activity, participants will be able to:

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

CNE/CME INSTRUCTIONS

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

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

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

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

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

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

CNE/CME QUESTIONS

1. Which is true regarding liability risks posed by frequent ED patients, according to **Dan Groszkruger**, JD, MPH?
   A. EPs cannot be held liable for the patient's failure to adhere to repeated instructions to obtain follow-up care under any circumstances.
   B. A cursory examination can harm the EP's defense.

C. It is not advisable for EPs to document that physical exam findings and test results were inconsistent with the patient's claimed symptoms.
D. EPs should not document the patient's exact words regarding their response to treatment.

2. Which is true regarding specialist consultation, according to **Ken Zafren**, MD, FAAEM, FACEP, FAWM?
A. If the EP needs specialist consultation to manage a patient effectively, failure to do so could result in a successful lawsuit against the EP.
B. If an EP thinks it is possible that an abdominal pain patient could have a surgical abdomen but the diagnosis is not yet clear, the EP can safely send the patient home without a consult.
C. The EP cannot be held liable for discharging a patient when the EP believes the patient should be admitted, as long as it's clearly documented that the consultant recommended this without having seen the patient.
D. If the consultant recommends a patient be discharged from the ED, the EP is obligated to discharge the patient.

3. Which is true regarding documentation of disagreements with consultants regarding a patient's admission, according to **John Burton**, MD?
A. EPs should give as much detail as possible regarding heated discussions with an admitting physician regarding a patient's admission.
B. Pursuing unprofessional behavior should be directed to the local medical staff office and not detailed in the record.
C. If EPs document a difficult interaction, they should not make the other provider aware they will be doing so.
D. "Pointing fingers" at the consultant is always legally protective for EPs.