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Is Georgia's Emergency Care Tort Reform Coming Apart?

By Robert A. Bitterman, MD, JD, FACEP
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In a series of recent decisions, the Georgia's appellate and supreme courts diluted application of the "clear and convincing gross negligence" standard installed by Georgia's tort reform statute; and they have also advanced "exceptions" to the law that allow plaintiff attorneys to circumvent the legislature's intended tougher standards required to prove medical malpractice.

This article will focus on the court's actions related to the "gross negligence" standard; a forthcoming *ED Legal Letter* issue will address the growing number of circumstances in which the Georgia courts have found "exceptions" to applying the tort reform act in emergency department cases.

Historical Perspective

In 2005, the Georgia legislature enacted a broad package of medical malpractice reforms, known as the Georgia Tort Reform Act, intended to ameliorate the "crisis affecting the provision and quality of health care services in this state" due to the escalating premiums and diminishing availability of medical liability insurance.[1] The two most significant and impactful elements of the law were its cap on non-economic damages for all medical malpractice claims and, specific to hospital-based emergency care, a more difficult burden of proof for plaintiffs when suing the hospital or physicians providing emergency care, such as the emergency physicians and on-call physicians in the ED, or obstetricians in the labor and delivery unit.[1]

In the first case to reach the Georgia Supreme Court, the justices unanimously declared the statutory non-economic damages cap of $350,000 to be unconstitutional.[2] It held that the cap violated the state's constitutional right to trial by jury, noting that their constitution plainly states that "the right to trial by jury shall remain inviolate."[3] To quote

the Georgia chief justice: "The very existence of the caps, in any amount, is violative of the right to trial by jury."[2]

However, the Georgia Supreme Court, in a sharply divided decision, did uphold, at least for emergency departments, the more difficult burden of proof/higher standards of liability necessary to prove a claim of malpractice against providers of emergency care.[4] The implementing statutory language is:

"In an action involving a health care liability claim arising out of the provision of emergency medical care in a hospital emergency department … no physician or health care provider shall be held liable unless it is proven by clear and convincing evidence that the physician or health care provider's actions showed gross negligence."[1,5]

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Unquestionably, by requiring plaintiffs to prove emergency physicians or hospitals committed gross negligence by a clear and convincing standard (rather than "ordinary negligence" by the usual "preponderance of the evidence" — a.k.a. the "more likely than not" standard), the legislature made it very difficult for plaintiffs to win malpractice cases related to emergency care. Early cases, such as the *Johnson v. Omondi* case, which is discussed at length below, seemed to bear out that notion.[6]

For example, in *Pottinger v. Smith*, the plaintiff incurred multiple injuries in a motorcycle accident. After evaluation in the emergency department by Dr. Pottinger, an emergency physician, the plaintiff was admitted to the hospital for neurological observation by the on-call neurosurgeon. In the ED, Dr. Pottinger obtained a head CT, spinal imaging, and X-rays of the patient's left tibia and fibula.[7] Dr. Pottinger relied on the hospital's radiologist to interpret the X-rays; the radiologist found a "minimally displaced fracture of the left fibular head" and "no other fracture or dislocation."[7]

Three weeks later, an orthopedic surgeon read the same the lower extremity X-rays done in the ED and found a "more serious fracture that required surgery" (the opinion doesn't reveal exactly what was fractured). Smith subsequently sued Dr. Pottinger, claiming that the doctor's failure to read the X-rays herself, failure to discover the "serious fracture," and failure to promptly consult an orthopedic surgeon was "gross negligence." The plaintiff even obtained an emergency physician "expert," who opined that Dr. Pottinger's reliance on the radiologist to read the X-rays was itself "grossly negligent."[7]

Fortunately, the court rejected the plaintiff's "expert" opinion, noting that Georgia defines "gross negligence" as "the equivalent to the failure to exercise even a slight degree of care," and that relying on a trained, credentialed radiologist to interpret X-rays could hardly be judged a failure to exercise a slight degree of care.[7] The court found its decision as "plain and indisputable," stating that "even assuming there was some evidence to create a jury issue as to whether Dr. Pottinger's actions were negligent, there is no evidence, and certainly no 'clear and convincing' evidence by which a jury could conclude the Pottinger failed to exercise even slight care and was, therefore, grossly negligent."[7]

As a result of favorable court decisions such as Pottinger, the state's largest liability insurance carrier, MagMutual, has provided a series of premium

rate decreases for emergency physicians in Georgia during the past half-dozen years.[8] However, celebration in the emergency medical community may be short lived.

The Case of *Shaquille Johnson v. Dr. Omondi*

In 2007, a trial court threw out Johnson's lawsuit against Dr. Omondi, also an emergency physician, stating that there was no way a jury could find in a clear and convincing fashion that the physician committed gross negligence. In other words, the judge dismissed the case as a matter of law, preventing the case from ever reaching a jury just like in the Pottinger case (called dismissal on a "motion for summary judgment," which normally is a very difficult threshold for defendants to attain). In 2012, the trial court decision was upheld by the Georgia Court of Appeals.[6]

The facts of the case are illustrative to understanding how the Georgia Supreme Court ultimately overturned the appellate court's decision and, thus, forced the physician to eventually face a jury trial for allegedly providing grossly negligent care in the emergency department.

Shaquille Johnson, who was 15 years old, presented to the ED one week post-arthroscopic knee surgery complaining of chest pain. He was triaged by a nurse, and Dr. Omondi obtained a history, performed a physical exam, reviewed the vital signs and pulse oximetry, administered anti-inflammatory medication (Toradol), which entirely resolved the patient's symptoms, and obtained an EKG and chest X-ray, which he interpreted as negative. The physician considered but ruled out asthma, pericarditis, pneumothorax, myocardial infarction, and pulmonary embolism. He discharged the teenager with a diagnosis of pleurisy and a prescription for an anti-inflammatory agent, instructing him to return to the ED if his symptoms continued. Two weeks later, Johnson returned to the ED and rapidly died from bilateral pulmonary embolisms (PE).[6,9]

The family sued Dr. Omondi for money damages. Their professional experts testified that the 15-year-old's symptoms were "classical" for PE, the response to Toradol "totally irrelevant," and reliance on improvement with Toradol to rule out PE "ridiculous." The experts also opined that Dr. Omondi misread the EKG, misread the CXR, and "grossly deviated" from the standard of care by failing to order a D-dimer, lung scan, ultrasound, and/or CT scan to rule-out pulmonary embolism.[6,9]

Nonetheless, the lower courts ruled that the plaintiff failed to overcome the "greater quantum and a higher quality of proof" required under Georgia's new "gross negligence" by "clear and convincing evidence" standard.[6] Under long established precedent, the Georgia Supreme Court defined "gross negligence" as "the absence of even slight diligence, and slight diligence is defined as that degree of care which every man of common sense, however inattentive he may be, exercises under the same or similar circumstances. In other words, gross negligence has been defined as equivalent to the failure to exercise even a slight degree of care, or lack of diligence that even careless men are accustomed to exercise."[4]

That Court has also defined "clear and convincing evidence" as "an intermediate standard of proof," greater than "the preponderance of evidence," but less than the "beyond a reasonable doubt" standard applicable in criminal cases.[10]

Thus, the lower courts held that in order for the plaintiffs to reach a jury trial, they must demonstrate that a genuine issue of material fact existed — not as to whether Dr. Omondi exercised ordinary care (i.e., that degree of care and skill customarily exercised by the medical profession) — but, rather, they must show the existence of "clear and convincing" evidence that Dr. Omondi did not exercise even slight care.[6]

In the judgment of the trial judge and the appellate court judges, Dr. Omondi clearly provided at least a "slight degree of care," and, accordingly, they determined that no reasonable jury could conclude in a clear and convincing manner that Dr. Omondi was grossly negligent.[6]

The Georgia Supreme Court Opinion in *Johnson v. Dr. Omondi*

The high court began its analysis by acknowledging that Dr. Omondi was a physician who was providing emergency medical care in a hospital emergency department as contemplated by the Georgia Tort Reform Act. Accordingly, it was one of those cases in which the state legislature had placed a higher evidentiary burden on plaintiffs such as Johnson (i.e., any departure from accepted standards of care must be shown, by clear and convincing evidence, to be gross negligence).[1,9]

The court laid out the definitions in the statute, as noted in the appellate opinion, but also highlighted the fact that the case was a "motion for summary judgment," not a decision on the merits of the case. Thus, to prevent the lawsuit from

being dismissed, the plaintiff only needed to present sufficient evidence that raised a genuine issue of material fact. It would then be up to the fact finder — the jury — to decide whether the facts constituted sufficient evidence of gross negligence.[9]

The court accepted the premise, as in the Pettinger case, that courts could resolve issues of gross negligence on their own in "plain and indisputable cases." However, it looked at the same facts, the same evidence, and the same testimony as the trial and appellate courts and concluded just the opposite — that there were genuine factual issues under which a reasonable jury could find by clear and convincing evidence that Dr. Omondi was grossly negligent. The Georgia Supreme Court reversed the lower court opinion and left Dr. Omondi to face a jury trial in the near future.[9]

The court focused and relied heavily on the expert testimony provided against Dr. Omondi. As noted above, the medical experts opined that Dr. Omondi's failures amounted to "gross deviations" from the required standard of care and proximately caused Johnson's death.[9]

In addition to the evidence provided by the plaintiff's experts, Dr. Omondi had himself acknowledged that he had misread the EKG by failing to note the Q3 abnormality, and that the left ventricular hypertrophy shown by the EKG and the CXR was a condition that could indicate a pulmonary embolism. Dr. Omondi also admitted that a pulmonary embolism cannot be seen on an X-ray, and that the proper way to identify a pulmonary embolism is through a CT scan. He testified that he could have ordered a CT scan, and that a CT scan is the only test that is needed to diagnose a patient who may have a pulmonary embolism.[9]

The experts further testified that Dr. Omondi's actions amounted to gross negligence under the customs and standards of emergency physicians in similar circumstances. While the court recognized that "a mere conclusory expert opinion with respect to the existence of gross negligence does not create a jury issue,"[11] that principle did not apply in this case since the medical experts' opinions were based upon specific facts showing the manner in which Dr. Omondi's actions departed from the standard of care.[9]

Consequently, the Georgia Supreme Court determined that there was sufficient evidence that "a reasonable jury could find, by clear and convincing evidence, that in addressing Johnson's symptoms, Dr. Omondi acted with gross negligence (i.e., that he lacked 'the diligence that even careless men are accustomed to exercise).'"[9]

Comment

Note that the court's reliance on the expert testimony will only encourage plaintiffs, and consequently their "expert," to routinely bellow harsh outlandish accusations and ad hominem attacks on physician defendants in an effort to avoid summary judgment under Georgia's gross negligence standard. Every claim will allege the physician's examination and medical decision-making was "grossly deficient," "grossly negligent," or a "gross deviation" from the standard of care; and every rejoinder by the defendant will be labeled "ridiculous" or "totally irrelevant."

Indeed, as one of the judges wrote: "If an expert affidavit is all that is needed to preclude summary judgment, then Georgia's tort reform statute would be rendered meaningless."[9]

The court also made a big deal of the emergency physician's failure to order the proper diagnostic test to rule out a PE. Dr. Omondi did not order the chest CT simply because he judged that a pulmonary embolism was so unlikely that the test was not indicated, which the medical experts opined was due to his failures to properly assess and recognize the classic symptoms of the emergency condition.

The court distinguished Dr. Omondi's case from the Pottinger case by noting that Dr. Pottinger had ordered the correct diagnostic test and then relied on another professional's interpretation of the test to determine the course of treatment. The Georgia Supreme Court agreed that in those circumstances, a reasonable jury would not be able to find that the physician "failed to exercise even slight care and was, therefore, grossly negligent." Dr. Omondi, however, did not order the correct test, and moreover, unlike Dr. Pottinger, Dr. Omondi did not rely upon another physician's findings in his assessment; rather, he read and misinterpreted Johnson's chest X-ray and EKG results himself.[9]

In fact, Dr. Omondi's circumstances were strikingly similar to those in a 2012 appellate decision, *Knight v. Roberts*, which ruled that an emergency physician was not entitled to summary judgment in a malpractice lawsuit based upon evidence that he had failed to consider and obtain a CT scan in a patient with chest pain to diagnose an aortic dissection.[12] The emergency physician had obtained a chest X-ray, but the plaintiff's experts claimed that the chest X-ray was not the correct diagnostic test to rule out a dissection.[12]

Not every patient presenting to the ED with chest pain, abdominal pain, or a headache needs a CT to rule out PE, aortic dissection, appendi-

citis, or a subarachnoid hemorrhage. Georgia's tort reform was intended to allow physicians to use their expertise and judgment to discern when CTs or other diagnostic studies are indicated, without being subject to litigation every time an expert witness retrospectively with hindsight bias disagrees with that judgment. The end result of court cases like *Omondi*, is that whenever there is a mere scintilla of consideration given to these major diseases, emergency physicians will be highly motivated to "just order the test" as defensive medicine, tests which are not without risks themselves. The physician's threshold for doing the test may end up being much lower than it would otherwise be, based purely on competent clinical practice.

The Omondi decision may also incite emergency physician groups to insist that their hospitals require the radiologists to read all X-rays and imaging studies in real time before the patient leaves the ED. Not only is this good care (and it should be the standard of care with today's teleradiology technology), but it would insulate the emergency physicians to some degree from medical malpractice claims due to Georgia's gross negligence law when relying on the radiologists to interpret the diagnostic studies.

The net result of the Omondi decision, from a litigation perspective, may mean that more malpractice claims in Georgia will not be decided on a motion for summary judgment, but will instead proceed to a jury trial. Not ideal, but it doesn't mean that the legislature's intent in enacting tort reform will have been frustrated. As one of the justices aptly noted at trial: "It always will be harder to prove 'gross negligence' than 'ordinary negligence,' and it always will be harder to prove fault by clear and convincing evidence than by a mere preponderance of the evidence."[9] Thus, no one should be surprised that emergency department malpractice cases that come under the Georgia law produce far more defense verdicts at trial than in ordinary malpractice cases. After all, it should be awfully difficult to prove that a conscientious, caring, and compassionate emergency physician "failed to exercise even a slight degree of care" when examining and treating patients in the emergency department. ■

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EP "Anchoring" on a Diagnosis Can Result in Malpractice Claim

Errors are "common, powerful, and problematic" for EPs

A patient with a chief complaint of back pain also reported leg weakness to the emergency physician (EP) evaluating him, but the EP assumed the weakness was related to the back pain. As the patient was about to be discharged, a second EP learned that the patient was incontinent, but failed to question the previous assessment.

"Had he put two and two together, this now would have been back pain plus weakness plus incontinence — an easy call for cord compression," says **Robert M. Wachter**, MD, professor and associate chairman of the Department of Medicine at University of California — San Francisco, who reviewed the case as an expert witness.

The patient ended up paralyzed from the waist down, and sued the hospital and the involved EPs. "The case settled for hundreds of thousands of dollars," says Wachter.

Wachter says this case is a prime example of "anchoring" — a cognitive error that occurs when a physician latches on to a diagnosis and fails to consider alternatives.

"The primary techniques to avoid anchoring bias are known as 'meta-cognition' — literally, thinking about your thinking," he says. This involves EPs asking themselves: "What is the worst thing this could be? If I come in tomorrow and find out I got the diagnosis wrong and the patient did poorly, what would the correct diagnosis be?"

Computerized decision-support tools can be helpful in alerting the EP to consider alternative diagnoses, says Wachter, "but the EP has to recognize his or her uncertainty."

To avoid anchoring bias, EPs must review the differential diagnosis and consider other possible diagnoses before coming to any conclusions, says **Ken Zafren**, MD, FAAEM, FACEP, FAWM, EMS 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 cases involving EPs that involved cognitive errors, including "anchoring," reviewed by Zafren:

• A 15-year-old boy was diagnosed with a cerebral arteriovenous malformation that was apparently an incidental finding on a non-contrast CT obtained to evaluate sore throat with neck pain. He was referred to a neurosurgeon, who saw him three days later and documented a normal neurologic examination.

Three days after seeing the neurosurgeon, the patient presented to an ED with the chief complaints of vomiting and possible aneurysm. The patient also complained of headache, neck pain, and unsteady gait.

The EP was aware of the abnormal CT, and documented that the patient had a stiff neck. "The EP diagnosed vomiting and gastroenteritis and discharged the patient to home, where he deteriorated and subsequently died from a ruptured arteriovenous malformation (AVM)," says Zafren. "The case was ultimately settled."

Zafren says the cognitive errors in this case include anchoring bias, premature closure, and failure to connect the patient's symptoms to the recently diagnosed AVM.

• An 11-year-old girl was seen in the ED for abdominal pain, fever, and vomiting. "She was tender to palpation on abdominal examination. The EP diagnosed her with 'gastritis,'" says Zafren. The EP also diagnosed otitis media and treated the patient with amoxicillin, although the patient had no complaint of ear pain.

The patient's abdominal pain worsened at home. The patient's mother called the ED and was told to give the amoxicillin two days to work. The patient subsequently returned to the ED, where she was diagnosed with ruptured appendicitis.

"Her peritonitis was so severe that the right ovary had to be removed. The case was settled," says Zafren, adding that cognitive errors in this case include anchoring bias and premature closure.

"The EP testified at deposition that otitis media can cause abdominal pain," he says. Otitis media can be associated with fever and vomiting, Zafren notes, but is unlikely to cause abdominal pain with tenderness on exam. "Abdominal pain in a patient with an appendix should always prompt consideration of appendicitis."

• A 43-year-old man who was a T12 paraplegic with neurogenic bladder as the result of a motor vehicle crash many years previously, with a history of poorly controlled diabetes, presented to the ED with a two-day history of right flank pain and nausea, and was seen by a physician's assistant (PA).

The patient's urinalysis was consistent with infection and positive for glucose, and a fingerstick blood sugar was 358.

"The PA allegedly had a 'discussion' with the EP. The PA diagnosed muscle spasm of the back and diabetes and did not prescribe antibiotics," says Zafren.

The patient was subsequently seen by a nurse practitioner (NP) at the office of his primary care physician, and was prescribed cotrimoxazole based on the positive urine culture that showed > 100,000 mixed flora. The patient had a second follow-up visit with his primary care physician.

"At this visit, the patient was febrile. The primary care physician diagnosed infected decubitus ulcers and prescribed cephalexin," says Zafren.

Three days later, the patient had a cardiac arrest at home. At autopsy, the patient had bilateral renocortical abscesses that grew the same organisms as the urine. "The cause of death was listed as bacterial sepsis due to chronic pyelonephritis," says Zafren. "The case against the PA was settled."

Zafren says cognitive errors in this case include anchoring bias and failure to assure proper follow-up. "The PA thought the back pain was musculoskeletal and communicated this to the primary care office," says Zafren. "This patient had a high likelihood of pyelonephritis, and should have been admitted considering his underlying comorbidities."

The NP had correctly diagnosed urinary tract infection, but, like the PA, ignored red flags for pyelonephritis.

"The primary physician compounded the problem by ascribing the fever to decubitus ulcers, by not repeating the urinalysis, and by not recognizing the likelihood of pyelonephritis as the source for the fever," says Zafren.

EP "Anchored" on Concussion

Anchoring bias is "one of the most common, powerful, and problematic" errors made by EPs, says **Bruce Wapen**, MD, a Foster City, CA-based emergency physician.

In one recent case, a 15-year-old girl reported the sudden onset of severe headache, vomiting, slurred speech, facial droop, and paralysis on the side of her body opposite from the side of the headache. There was no history of head trauma or loss of consciousness. She was airlifted to a stroke receiving center, where the flight nurse gave a verbal report to the triage nurse, which was entered into the ED's electronic medical record. "By the time she arrived in the ED, her symptoms had pretty much resolved, except for waxing and waning facial asymmetry," says Wapen.

After the EP evaluated the patient, he documented that the patient had struck her head and was rendered unconscious, after which she experienced brief, one-sided weakness that was now resolved.

"Because the physician got, from somewhere, a history of head trauma and loss of consciousness, he thought the patient had a concussion and he anchored on that. He didn't have [transient ischemic attack] or [cerebrovascular accident] in his differential," says Wapen.

The work-up consisted of a head and neck CT scan, which did not show an intracranial bleed or neck fracture, and the patient was discharged with a diagnostic impression of "concussion." The patient returned the next day to a different ED, and a CT angiogram showed evidence of an internal carotid dissection with brain infarction.

The diagnosis was missed because the first EP "anchored" on concussion and did a work-up appropriate for that problem, Wapen says.

Anchoring bias kept the first EP from making the correct diagnosis, says Wapen, "or at least having the correct diagnosis in the differential diagnosis, which should have led to additional imaging, admission to the hospital, and consultation with a pediatric neurologist." ■

Sources

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Patient History Is Frequent Issue in ED Med/Mal Claims

It may be "incomplete or downright incorrect"

A patient's history frequently becomes an issue in malpractice claims against emergency physicians (EPs), says **Phillip B. Toutant**, Esq., an attorney in the Southfield, MI, office of The Health Law Partners. Toutant was involved in a recent case in which a young woman was admitted through an ED with a complaint of diffuse abdominal pain, nausea, and vomiting.

"She had a complicated medical history, including chronic pancreatitis, and a recent history of eating spicy food, which had caused her abdominal pain in the past," says Toutant.

Additionally, her labs revealed leukocytosis. Her symptoms were evaluated, and she was medicated and monitored for a number of hours and then discharged.

"She did not receive an abdominal CT or other imaging studies," says Toutant. "Two days later, she returned with a ruptured appendix, resulting in sepsis and a stay in the intensive care unit over 30 days."

The ED medical records described only "diffuse abdominal pain." "This became relevant, as the patient's Modified Alvarado Score was dispositive of whether the patient was to be admitted, or discharged, given that no imaging studies were performed," says Toutant.

Using Modified Alvarado, the patient had nausea/vomiting (one point), and leukocytosis (two points), amounting to a score of three points.

If the patient's history included a complaint of pain in the right iliac fossa, she would have had a Modified Alvarado Score of four, and should have been admitted. There was no evidence of this complaint in the patient's history and physical or the ED nursing notes.

"Nonetheless, when the patient was deposed, she claimed that when she was in the ED, she complained of pain in the right iliac fossa, despite this being contrary to the clinician's contemporaneous charting of just 'diffuse abdominal pain,'" says Toutant.

The EP who evaluated the patient accurately documented the patient's description of her pain. "However, one significant factor that would have improved the physician's defense would have been if he specifically documented the absence of complaints in the patient's history," says Toutant — such as "no right iliac fossa pain" and "no fever." "This would have made it substantially easier to prove the patient had not made such a complaint," he says.

Patients Dispute Accuracy

Robert D. Kreisman, JD, a medical malpractice attorney with Kreisman Law Offices in Chicago, recently handled a case in which the patient claimed he stated clearly to the EP that he had suffered a fractured clavicle that occurred during a recent orthopedic procedure, and that he was seeking medical attention because of his increased pain level.

However, the ED chart stated that the patient had fallen while running at a beach. "Those facts were completely different than what had been given by the patient in the ED or the facts surrounding his injured clavicle," says Kreisman. "The difference in his care may have been insignificant, but the risk remained that his treatment plan may have been altered given the mechanism of his true injury."

In this case, the inaccurate ED documentation could affect the outcome of future litigation, in that the patient's injury was caused by a surgeon and not by a fall.

In another case, a patient reported that he had fractured his ankle after falling in a hole in his basement, but the EP recorded his injury as occurring when the patient was running in a recent charity race.

"The obvious way of eliminating possible claims of negligence because of a patient's history would be to accurately record the history," says Kreisman. "Many ED physicians dictate their entries shortly after they render their care."

The sooner the documentation is done, the more likely the entries will accurately reflect the care and treatment given to the patient, says Kreisman, including the history, which will most likely be later reviewed by another practitioner who relies on the accuracy of the chart for further treatment.

"ED physicians can protect themselves from potential liability by insisting that the chart correctly reflect the history of the patient, the care given, and the medical providers who offered that care," says Kreisman.

Differential "Becomes Distracted"

If patients don't give an accurate history, the EP's differential "becomes distracted. The patient's contributory negligence in not disclosing the information would become critically important to the defense," says **Julian Rivera**, JD, a partner at Husch Blackwell in Austin, TX.

Rivera says that giving patients the opportunity to answer questions in writing, whether electronically or on paper, can make malpractice claims more defensible.

"Any opportunity for the patient to input the data themselves helps, because that shows that it wasn't the mistake of the EP in misunderstanding the patient, but the patient's own self-report," he explains.

For instance, some medical record systems allow patients to add information to the record in their own handwriting or directly into the electronic medical record.

"Facts entered into the record by the patient themselves, rather than by a provider or scribe, are compelling and less subject to manipulation by lawyers who try to attack an EP later," says Rivera.

The EP's efforts to gather a patient's history must be "reasonable" and based on good professional judgment, emphasizes Rivera.

"EPs who want to reduce their risk need to engage their leadership and technology teams to maximize the effectiveness of the EPs' history information gathering," says Rivera, adding that the lack of interoperability of information technology systems between hospital systems complicates data gathering.

Juries understand that the EP has to rely on patient trustworthiness and candor, adds Rivera.

"Believability and trust are incredibly important to juries," he says. "Examples in the contemporaneous chart of the patient's lack of candor or the patient's false statements can completely undermine cases launched against the EP." ■

Sources

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Change of Shift Is "Rife with Potential Legal Exposure" for Both EPs

A recent malpractice case involved an elderly man who was diagnosed with a gastrointestinal (GI) bleed by an emergency physician (EP), who determined that the patient should be admitted. While the patient was being held in the emergency department (ED) waiting for an available inpatient bed, another EP came on shift.

After about an hour, the patient was brought upstairs. "Once in the room, his condition precipitously declined and the patient died," says **Scott O'Halloran**, JD, an attorney in the Tacoma, WA, office of Williams Kastner, who defended the hospital in the resulting malpractice suit. "There was absolutely no documentation in the patient's chart by the oncoming EP."

The first EP was sued, and the plaintiff failed to realize that a second EP was on duty during the period immediately before the patient left the ED.

"It wasn't even until two days before trial that the first EP went back and looked at his shift notes for that day, and realized that he wasn't even on shift at the time that the patient declined," says O'Halloran. The plaintiff wrongly assumed that the first EP was caring for the patient the whole time, since the EP had never documented that he had transferred care to the oncoming EP.

The case alleged that the patient was wrongly diagnosed with an upper GI bleed, which was in fact a lower GI bleed — a more problematic and acute situation that they argued called for more emergent care.

"They still had that argument against the first EP, but their second argument was that the patient was left unattended in the ED," he says.

The plaintiff argued that it made little difference which EP was on shift at the time, as the hospital was vicariously liable for the actions of all the EPs. "But the court ruled that the responsibility was on the plaintiff to have discovered this information," says O'Halloran.

Regardless, the case went to trial, and resulted in a defense verdict. O'Halloran says the claim could have been avoided altogether if there had been a better handoff.

"The case spotlights the need for good documentation by the offgoing EP and the oncoming EP, to pinpoint at what point the oncoming EP is taking responsibility for the patient," he says. If the oncoming EP had been named in the suit, the case would have been much harder to defend, O'Halloran adds.

"Since there was no documentation that she was even aware the patient was in the ER, she would have a tough time establishing that she even looked at the patient," he says.

Oncoming EP Never Saw Patient

Another malpractice case involved a patient who presented with difficulty breathing and a swollen tongue. The EP correctly diagnosed him with an allergic reaction.

The patient's condition appeared to improve after an antihistamine and steroid were given, and the EP put in the order to discharge the patient. After the oncoming EP came on shift, the patient remained in the ED for about 45 minutes. "The ED nurse commented in the record that the patient was still having problems swallowing," says O'Halloran. "But the oncoming EP assumed the patient wasn't their responsibility since the patient was already discharged, so the EP never came in to see the patient."

The patient returned to the ED several hours later with worsening symptoms. "The EP was unable to do a tracheotomy in time, and the patient died," says O'Halloran. There were several allegations in the resulting malpractice suit, which was settled, "but the one that worried us a lot was the period of time in which the patient was discharged, and was clearly not improving, but nobody really examined him," he says.

Evaluate Patient "From the Ground Up"

Reliable information transfer, proper documentation, and patient acceptance are essential components of handoffs in the ED, says **Robert Broida**, MD, FACEP, COO of Physicians Specialty Limited Risk Retention Group, a captive professional liability insurance company serving the Canton, OH-based Emergency Medicine Physicians medical group.

"Rounding" handoffs, in which the outgoing EP personally introduces the incoming EP to each patient, are best for the patient and information transfer, but are time-consuming, notes Broida.

"The large variety of data-based techniques, such as EDIS solutions and Safer Sign Out, are great for information transfer, but outgoing physician fatigue and patient satisfaction are not well-addressed," says Broida. Broida says the best solution is the "Do-Over."[1]

"Here, the incoming physician treats the patient as an entirely new encounter," he says. "They perform and document a full evaluation from the ground up."

The key to this process is that the oncoming EP feels personally responsible for the patient, says Broida. "This is lacking to some degree in all other methods where the patient is viewed as 'belonging' to the departed physician," he adds.

Damian D. Capozzola, JD, of The Law Offices of Damian D. Capozzola in Los Angeles, CA, says change of shift is "rife with vulnerabilities and potential legal exposure" for EPs.

The EP whose shift is ending may assume that the incoming EP will conduct certain tests or investigate particular diagnoses. The incoming EP may incorrectly assume that the prior EP either already did so or had a reason for not doing so.

"When you add to that the chaotic environment that can pervade an emergency room, it becomes very difficult to avoid information slipping through the cracks," says Capozzola.

Plaintiffs' attorneys may be especially attracted to change of shift lawsuits for precisely this reason, he says.

"They present the attorney with the opportunity in litigation to present a compelling timeline of all the things that were not done," says Capozzola. The attorney can allege that the departing EP was more concerned with getting back to his or her personal life than assuring the patient was adequately cared for by the incoming EP.

"Even better for the plaintiff's counsel, the involvement of two physicians may mean two separate insurance policies to pursue," says Capozzola. "If the physicians start to point fingers at one another, which may be a natural reaction for each physician, the plaintiff's counsel will further benefit."

Capozzola says EPs should take extra care to document information at the end or beginning of a shift.

"EPs should keep in mind that at some point they may need contemporaneous documentation to defend either the steps that were taken to hand off the patient with the benefit of all information obtained thus far, or what steps were taken to treat the patient in light of the information obtained at the start of the shift," says Capozzola.

Change of Shift "Very Vulnerable Time"

Handoffs are "obviously a very vulnerable time" in the ED, says **Corey M. Slovis**, MD, professor and chairman of the Department of Emergency Medicine at Vanderbilt University Medical Center in Nashville, TN. "The outgoing EP feels pressure to tie everything up as quickly as possible, and the incoming EP may be distracted by all that's waiting for him or her to do as they begin the shift, and is not listening carefully. That itself is a setup for error," says Slovis.

Patients being signed out to an oncoming EP "have the potential to bring out the worst in us," says Slovis. "Signouts really ought to get the best care — they ought to have two EPs looking at them. But sometimes they really just have one, and somebody's name."

Oncoming EPs may fear getting "too involved" with a patient who is already scheduled to be discharged or admitted. "It's so much easier to just let them leave, instead of pulling that thread that could unravel everything," says Slovis. "Even though the patient was signed out to us, we don't always 'own' that patient."

Slovis says EPs should consider these practices to reduce risks of handoffs:

• Use a pre-agreed, organized signout plan in which the patients who need the most thought and attention are presented first.

"And as the EPs go through it, besides the little blurb about what's wrong, two things need to be done on every single signout," he says. Oncoming EPs must answer the questions "What's pending?" and "What do I need to do prior to safely discharging or admitting this patient?"

• For any patient who has anything potentially serious wrong who is within an hour or so of being discharged or admitted, or any patient in the middle of a comprehensive workup, the oncoming EP should go see the patient.

"Spend 30 to 60 seconds going in to see the patient, so you have a visual image of how that patient looked at the time of signout," says Slovis.

• For any patient being discharged after a significant workup, the oncoming EP should indicate that he or she evaluated the new test results and thinks that the patient is now stable for discharge.

• The outgoing EP should indicate at what time the care of the patient was transferred to the oncoming EP.

"There needs to be a clear change in responsibility," says Slovis. "And the oncoming physician needs to know that anything that happens subsequent to that signout is going to be on them." ■

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1. Cheung DS, Kelly JJ, Beach C, et al. Improving handoffs in the emergency department. *Ann Emerg Med* 2010; *55*(2):171-180.

Sources

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CNE/CME INSTRUCTIONS

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

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2. Scan the QR code below, or 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.*

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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.

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CNE/CME QUESTIONS

1. Which is true regarding malpractice claims against emergency physicians (EPs) involving a patient's history, according to **Julian Rivera**, JD?
   A. EPs should not document the absence of complaints in the patient's history.
   B. The standard of care requires EPs to determine the name of the patient's physicians and to fax requests for medical records.
   C. The EP's efforts to gather a patient's history must be reasonable and based on good professional judgment.
   D. EDs should not allow patients to add information to the record in their own handwriting or directly into the electronic medical record.

2. Which practices can reduce risks during change of shift in the emergency department (ED), according to **Corey M. Slovis**, MD?
   A. EDs should use a pre-agreed, organized signout plan, in which the patients who need the most thought and attention are presented first.
   B. It is not necessary for the oncoming EP to see patients who are within an hour or so of being discharged or admitted, if the offgoing EP has documented that the patient is stable for discharge.
   C. It is not advisable for the oncoming EP to document that he or she thinks the patient is stable for discharge, if discharge orders were already put in by the outgoing EP.
   D. The outgoing EP need not document at what time the care of the patient was transferred to the oncoming EP.

3. Which is recommended to reduce liability risks involving change of shift in the ED, according to **Robert Broida**, MD, FACEP?
   A. EPs need not specify the point in time they sign out a patient to an oncoming EP.
   B. The incoming physician should treat the patient as an entirely new encounter, and perform and document a full evaluation.
   C. It is not necessary for incoming physicians to perform and document a full evaluation if patients have already been evaluated by the offgoing EP.
   D. The oncoming EP is very unlikey to be held liable for a bad outcome if the patient was already discharged by the offgoing EP.

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. ■

ED Legal Letter

Reader Survey 2014

In an effort to ensure *ED Legal Letter* is addressing the issues most important to you, we ask that you take a few minutes to complete and return this survey. The results will be used to ensure you are getting the information most important to you.

Instructions: Mark your answers by filling in the appropriate bubbles. Please write in your answers to the open-ended questions in the space provided. Return the questionnaire in the enclosed postage-paid envelope. The deadline is **July 1, 2014**.

Questions 1-12 ask about coverage of various topics in *ED Legal Letter*. Please mark your answers in the following manner:

	A. very useful	B. fairly useful	C. not very useful	D. not at all useful
1. Pulmonary embolism in the ED (June 2013)	O A	O B	O C	O D
2. Pain management signs in the ED (July 2013)	O A	O B	O C	O D
3. Infectious disease malpractice (Aug. 2013)	O A	O B	O C	O D
4. Drugs, alcohol, and disposition (Sept. 2013)	O A	O B	O C	O D
5. New York high court ruling (Oct. 2013)	O A	O B	O C	O D
6. Many EPs concerned about Risk of med/mal suits under ACA (Nov. 2013)	O A	O B	O C	O D
7. Informed consent (Dec. 2013)	O A	O B	O C	O D
8. Pain, legislators, and EMTALA (Jan. 2014)	O A	O B	O C	O D
9. EMTALA whistleblower enforcement (Feb. 2014)	O A	O B	O C	O D
10. Court ruling on legal responsibility (March 2014)	O A	O B	O C	O D
11. Electronic medical records (April 2014)	O A	O B	O C	O D
12. Georgia's emergency care tort reform (May 2014)	O A	O B	O C	O D

13. How would you rate your overall satisfaction with your job?

O A. very satisfied O B. somewhat satisfied O C. somewhat dissatisfied O D. very dissatisfied

14. Are the articles in *ED Legal Letter* written about issues of importance and concern to you?

O A. always O B. most of the time O C. some of the time O D. rarely O E. never

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	A. excellent	B. good	C. fair	D. poor
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