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Courts Carve Out Exceptions to Georgia's Emergency Care Tort Reform .....	cover
Failure to Diagnose Stroke Claims Have These Fact Patterns .....	78
Not Giving tPA? EPs Must Protect Themselves Legally.....	79
EMR Charting "Creates New Areas of Liability" for EPs .....	80

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## Courts Carve Out Exceptions to Georgia's Emergency Care Tort Reform

By Robert A. Bitterman, MD, JD, FACEP  
Contributing Editor, ED Legal Letter

In a series of recent decisions, the state'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 discuss cases in which the Georgia courts found "exceptions" to applying the tort reform act in emergency department cases. The May 2014 issue of *ED Legal Letter* focused on the court's actions related to the "gross negligence" standard.<sup>1</sup>

Georgia's legislature enacted tort reform in 2005 specifically to protect hospitals and providers of hospital-based "emergency medical care," including emergency physicians and on-call physicians, by increasing the burden of proof on plaintiffs in malpractice litigation.<sup>2</sup> The statute reads:

"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."<sup>2,3</sup>

This "clear and convincing" evidence of "gross negligence" standard was upheld by the Georgia Supreme Court.<sup>4</sup> As a consequence, plaintiff attorneys now endeavor to avoid application of the higher standard by asserting that the care provided in the emergency department was not "emergency medical care" as defined by the Georgia law.

### The Case of *Bonds v. Dr. Nesbitt*

Mr. Bonds presented to the hospital emergency department with

nausea, vomiting, abdominal pain, and dizziness a few days after an outpatient diagnosis of pneumonia. The emergency physician on duty, Dr. Nesbitt, promptly evaluated Mr. Bonds and ordered blood tests, blood cultures, EKG, CXR, and a CT scan of Mr. Bonds' abdomen. He initiated treatment with IV fluids and IV pain medications, including Dilaudid and morphine.<sup>5</sup>

After a few hours, Dr. Nesbitt wrote an order to admit Mr. Bonds to the floor with a diagnosis of acute renal failure and hypertension, and documented that his patient's condition had improved and was stable. No inpatient beds were available, so Dr. Nesbitt continued treating Mr. Bonds until the admitting physician came into the ED to take over his care. Before he was moved to a room, Mr. Bonds became "agitated, tossing

on the bed and entangling himself in the wires from the machines" (most likely unrecognized hypoxia). After he was moved to the inpatient setting, Mr. Bonds "began thrashing about and complaining he could not breathe." A little while later he suffered a respiratory arrest and died.<sup>5</sup>

Mrs. Bonds sued Dr. Nesbitt for the death of her husband, alleging that Dr. Nesbitt failed to provide necessary emergency treatment, but the trial court threw out her lawsuit. The court decided that Dr. Nesbitt was providing "emergency medical care" as delineated by the Georgia tort reform statute and, therefore, the clear and convincing gross negligence standard applied — which it determined was impossible for Mrs. Bonds to prove.<sup>5</sup>

On appeal, Mrs. Bonds argued that at some point Mr. Bonds became stable and capable of receiving non-emergency medical services, and, therefore, the statute ceased to apply and she need only prove ordinary negligence by a preponderance of the evidence, not gross negligence by clear and convincing evidence.<sup>5</sup>

The court agreed with Mrs. Bonds, noting that the statute defines "emergency medical care" as bona fide emergency services provided after the onset of a medical or traumatic condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. The term does not include medical care or treatment that occurs after the patient is stabilized and is capable of receiving medical treatment as a non-emergency patient or care that is unrelated to the original medical emergency.<sup>6</sup>

The appellate court determined that initially there was no question that Dr. Nesbit was providing emergency medical care as defined by the statute: "Mr. Bonds was experiencing a medical condition with acute symptoms of sufficient severity, including pain, repeated vomiting, dizziness, and nausea, such that the absence of immediate medical attention could reasonably be expected to result in placing his health in serious jeopardy."<sup>5</sup>

However, it was then decided that the evidence was conflicting on the issue of whether Mr. Bonds at some point became stable and capable of receiving non-emergency medical services, thereby triggering an exception to the

**ED Legal Letter™**, ISSN 1087-7347, is published monthly by AHC Media, LLC, One Atlanta Plaza, 950 East Paces Ferry Road NE, Suite 2850, Atlanta, GA 30326. Periodicals Postage Paid at Atlanta, GA 30304 and at additional mailing offices.

**POSTMASTER:** Send address changes to ED Legal Letter, P.O. Box 550669, Atlanta, GA 30355.

**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: \$519 per year. Add \$19.99 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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#### Questions & Comments

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statute. Mrs. Bonds' expert witness testified that Bonds' condition never became stable while he was in the emergency room, while conversely Dr. Nesbitt determined at some point during his treatment Bonds was stable.<sup>5</sup>

Furthermore, the court said whether Mr. Bonds was ever stable was a question for the jury. Now a jury, not the courts, would decide whether Georgia's tort reform statute applied, and, thus, juries would decide whether to award malpractice damages using the "clear and convincing gross negligence standard" or the "more likely than not ordinary negligence" standard.<sup>5</sup> The case that followed Bonds in the appellate court highlights how much confusion the court's ruling created.

### **The Case of *Wadsworth v. PA-C Howland and Dr. Paustian***

Ms. Wadsworth presented to the ED via EMS with pain increasing in her feet to the point that she could no longer walk. She also complained that her feet were cold and that she was unable to warm them. The triage nurse determined the patient's condition to be "non-urgent," and noted that her feet were cold to the touch, but that she had "positive palpable" pulses in both feet.<sup>7</sup>

Mr. Howland, a physician's assistant (PA-C), examined the patient and discussed his findings with Dr. Paustian, the emergency physician on duty. Dr. Paustian, however, never examined the patient.<sup>8</sup> Mr. Howland considered three diagnoses: deep vein thrombosis, acute arterial occlusion, and cellulitis. He ordered a venous Doppler study, which was negative for thrombosis, and a CBC, which showed an elevated white blood cell count (WBC).<sup>7</sup>

Howland thought Wadsworth's feet were cool, not "cold," which he attributed to her diabetes. He did note diminished pulses in Wadsworth's feet, but he considered the pulses sufficient to rule out an acute arterial occlusion without the need to order a diagnostic study, such as an arterial ultrasound. Based on the elevated WBC, coupled with signs of redness and tenderness in Wadsworth's lower legs and feet, Howland came to a diagnosis of cellulitis. He treated Wadsworth with IV antibiotics and IV narcotics in the ED, and then discharged her with a prescription for oral antibiotics and pain medication.<sup>7</sup>

Although Wadsworth wanted to be admitted

to the hospital for observation, Howland deemed Wadsworth to be "relatively stable" during his examination, and he believed that her status had improved while she was in the emergency department. However, 12 hours after discharge, Wadsworth returned to the ED in critical condition with bilateral popliteal artery occlusions, which required below-the-knee amputations of both her legs.<sup>7</sup>

Wadsworth sued both Howland and Dr. Paustian and, at trial, the jury awarded her \$5,000,000.<sup>7</sup> The issue was exactly the same as in the *Bonds v. Nesbitt* case: Did the "exception" apply so that Wadsworth only had to prove ordinary negligence, not gross negligence by clear and convincing evidence? The trial judge had relied on the opinion of the appellate court in Bonds, holding that the jury was to decide if the PA-C and physician were providing "emergency medical care" or providing "medical care after the patient was stable and capable of receiving medical treatment as a non-emergency patient." Thus, the judge charged the jury via the verdict form as follows:

"If you find that the medical care provided by the defendants was 'emergency medical services,' you should apply the standard of gross negligence proven by clear and convincing evidence.

"If you find that the medical care provided by the defendants was not 'emergency medical services,' you should apply the standard of ordinary negligence proven by a preponderance of the evidence.

- 1. We, the jury, apply the standard of care of:
  - gross negligence.
  - ordinary negligence."

The jury checked the "ordinary negligence" box, and attached the \$5 million number for the plaintiff.<sup>7</sup>

On appeal, the defendants vehemently objected to the jury instructions, first arguing that whether a claim involves "emergency medical care" is a question of law for the court, not the jury, because it requires interpretation of the statute; and second, complaining that the language in the jury instructions didn't follow the statute (the judge used the term "emergency medical services" instead of "emergency medical care"). The court bypassed the second issue and noted it already determined in *Bonds v. Nesbitt* that whether the care provided was "emergency medical care" was a question of fact for the jury to decide.<sup>8</sup>

The defendants also argued that the jury

received no explanation or direction whatsoever concerning the medical terms and concepts contained in the definition of “emergency medical care” from expert witnesses or from the court. The appellate court brushed aside the defendant’s objections and allowed the jury’s decision to stand, stating that “none of the words or terms within that definition are beyond the ken of the average juror.”<sup>8</sup>

## Comment

The appellate court’s assertion on the “ken of the average juror” is rather remarkable and directly contradicted by the language of the statute. What “average juror” knows what constitutes “bona fide emergency services?” What “average juror” understands when “a medical or traumatic condition manifests by acute symptoms of sufficient severity ... such that the absence of immediate medical attention could reasonably be expected to result in placing the patient’s health in serious jeopardy,” much less what constitutes “serious impairment to bodily functions” or if and when a patient is “capable of receiving medical treatment as a non-emergency patient?”

The arguments made by the plaintiff and the defendants at the trial compared to their arguments proffered at the appellate level were also remarkable. At the trial, Wadsworth claimed she had an emergency medical condition (acute arterial insufficiency) that the defendants misdiagnosed and failed to stabilize by providing the necessary emergency treatment. Her expert witnesses testified unequivocally that her symptoms were limb-threatening, continued unabated both during and after her treatment in the ED, and only a narrow six-hour window existed to improve blood flow to her legs, which could not be done in an outpatient setting. Her experts further testified that cellulitis was also a “more life-threatening, more immediate type concern, emergency diagnosis” that necessitated treatment of the infection in the hospital.<sup>7</sup>

On appeal, however, Wadsworth argued that she was “stable and capable of receiving non-emergency medical treatment as a non-emergency patient” — that she did not receive “emergency medical care” as defined by the statute, thereby triggering an exception to the statute that allowed the jury to consider ordinary negligence under the preponderance of evidence standard.<sup>9</sup>

The defendants and their experts at trial asserted Wadsworth did not have an acute arterial

occlusion when she presented to the ED, that she did not have an emergency medical condition, did not need emergency medical care or admission, and that she was stable at the time of discharge.<sup>7</sup>

On appeal, they argued exactly the opposite: that their subjective judgment of the patient’s condition didn’t matter. Rather, the patient’s objective medical condition and acute symptoms of severe pain, an inability to walk, feet cold to the touch, and diminished distal pulses made it plainly evident that she required “emergency medical care,” as defined in the statute, and, therefore, the court should have applied the statute as a matter of law.<sup>9</sup>

It seems the jury may also have been confused by the judge’s charge on the different standards of liability.

If the jury truly believed Wadsworth was stable and only needed non-emergency medical treatment when it checked the “ordinary negligence” box on the verdict form, how could it award \$5 million? The verdict clearly indicates that the jury did not believe Wadsworth was stable or capable of discharge from the ED; it’s obvious they determined the defendants misdiagnosed Wadsworth and discharged her when she was still in need of emergency medical care. That, in fact, was the plaintiff attorney’s closing argument at trial: “These defendants could have saved her legs. They had the chance. They had six hours. They had a six-hour window that we know in which they could have saved her legs, but they didn’t.”<sup>7</sup>

In the end, it’s most likely the jury just went with its gut, deciding on the evidence that the PA-C and emergency physician should have better evaluated Ms. Wadsworth and should have diagnosed her emergency condition, and that their failure to do so resulted in her horrible outcome.

The real source of these adverse court opinions to providers is primarily the legislature’s inartful drafting of the statute, although the court’s interpretations certainly are a contributing factor.

In the *Bonds v. Nesbitt* case, the court should have argued that any patient admitted through the emergency department is not “capable of receiving medical treatment as a non-emergency patient,” and, therefore, the patient was receiving “emergency medical care” so that the statute continued to apply until the patient was discharged from the hospital. The patient may be “stable,” but the patient shouldn’t be deemed capable of receiving non-emergency care until leaving the hospital. Note that “stability” alone is insufficient to apply

the exception to the statute; the patient must be stable “*and* capable of receiving medical treatment as a non-emergency patient.”<sup>9</sup>

The legislature should have written the statute to encompass the full length of stay from ED visit through any necessary admission. There needs to be a “bright line” to application of the higher evidentiary burden, such that everyone knows it applies to all ED care and any resulting admission. It will not exactly encourage physicians to take emergency call for the ED if they don’t know in advance what standard of care will apply to their services, and instead will be subject to the whim of a lay jury deciding if their services constitute “emergency medical care.”

Similarly, if the patient is not admitted, the statute still should be written to cover any and all care provided in the ED. The legislature intended the statute to apply to EMTALA-mandated services.<sup>10</sup> The *Wadsworth v. Howland* case was essentially a “failure to diagnose an emergency medical condition case.” Said another way, the defendants were negligent in providing the EMTALA-mandated medical screening exam, the sole purpose of which is to determine if the patient has an emergency medical condition. Thus, any examination and treatment provided in determining whether the patient had an emergency condition should automatically be deemed “emergency medical care” covered by the Georgia statute.

Not knowing in advance what standards of care apply until a jury decides if the care provided was “emergency medical care” as defined by the statute will also hamper insurance settlement discussions, predictions of loss costs, and, ultimately, impact the liability premiums charged to providers. It will also create inconsistency in the application of the tort reform law across the various regions of the state.

Undoubtedly, now that juries are charged with interpreting the statute, expect plaintiff attorneys to not only routinely claim that the patient was “stabilized and capable of receiving medical treatment as a non-emergency patient,” but also to argue over whether the patient was provided “bona-fide emergency services” or the definition of a “nonemergency patient” — anything to create a jury question on whether the exception language of the statute should apply, and, thus, circumvent the legislature’s intent to provide a higher level of liability protection for providers of emergency department care in the state of Georgia.

Political expediency or the “half-a-loaf-is-better-than-nothing” theory may be the origin of the poor statutory drafting, but it sure creates havoc for providers and insurers, and is usually difficult if not impossible to fix after the fact.

*Dr. Bitterman’s additional comments:* When will emergency physician groups learn that any patient with potential life- or limb-threatening presentations should NEVER be seen by a mid-level provider alone? The emergency physician should ALWAYS personally examine these patients in the ED. ■

## REFERENCES

1. Bitterman, RA. Is Georgia’s Emergency Care Tort Reform Coming Apart? *ED Legal Letter*, 2014;25(5):49-55. For an additional detailed discussion of the gross negligence standard, and the role of expert witness testimony, see Sullivan W. “Gross Negligence”: A Slippery Slope for Dubious Expert Testimony. *Emergency Physicians Monthly*, March 12, 2014.
2. O.C.G.A. Section 51-1-29.5 (2013). Georgia Tort Reform Act of 2005.
3. O.C.G.A. Section 51-1-29.5 (2013); emphasis added. The more beneficial standards of liability also apply to “emergency medical care” provided in an obstetrical unit (labor and delivery unit), or in a surgical suite immediately following the evaluation or treatment of a patient in a hospital emergency department.
4. *Gliemmo v. Cousineau*, 694 S.E.2d 75 (Ga. 2010). See also *Watkins v. Anegundi*, 694 S.E.2d 647 (Ga. 2010).
5. *Bonds v. Nesbitt*, 747 S.E.2d 40 (Ga. Ct. App. 2013), certiorari denied.
6. OCGA § 51-1-29.5(a)(5), emphasis added.
7. *Wadsworth v. Howland*, No. 10C-13313-4 (Ga., Gwinnett Co. St. Sept. 24, 2012).
8. *Howland v. Wadsworth*, No. A13A0927 (Ga. Ct. App. Oct. 9, 2013), certiorari denied.
9. See, for example, *Quinney. v. Phoebe Putney Memorial Hospital*, in which the court of appeals held that the plaintiffs did not show that the patient was ever capable of receiving medical treatment as a nonemergency patient. In fact, the plaintiffs demonstrated just the opposite: that emergency medical care was necessary because the patient’s health was in serious jeopardy. Therefore, the court found that the services rendered by the defendants constituted “emergency medical care” as defined by the statute, and accordingly applied the higher evidentiary burden of gross negligence. *Quinney. v. Phoebe Putney Mem. Hosp.*, No. A13A1616. (Ga. Ct. App. Nov. 21, 2013).
10. “In all interpretations of statutes, the courts shall look diligently for the intention of the General Assembly” OCGA § 1-3-1(a). *Restina v. Crawford*, 424 S.E.2d 79 (1992).

# Failure to Diagnose Stroke Claims Have These Fact Patterns

*Patients don't fit typical profile*

**F**ailure to diagnose ischemic stroke is a common allegation in claims against emergency physicians (EPs) — even in emergency departments (EDs) at Primary Stroke Centers, according to **Gary Mims, JD**, a partner at Sickels, Frei and Mims in Fairfax, VA.

"I appreciate the demands on the ED doctor. But I am just one lawyer and I have seen a number of missed stroke cases in a major metropolitan area over a rather short period of time," he reports. Many of the plaintiffs were young and in good health.

"While these patients appear to be the least likely stroke victims, they are also the most likely to respond to timely intervention," Mims says.

With a young, healthy patient, it is statistically unlikely that stroke is the cause of symptoms of vomiting, headache, and vertigo, he acknowledges. "I would imagine that 95% of the time, stroke is not the cause, and that the ED doctor who doesn't consider stroke will most likely be right," says Mims. "But the consequences to that small percentage that have stroke is often catastrophic."

**Scott T. Heller, Esq.**, an attorney with Reiseman, Rosenberg, Jacobs & Heller in Morris Plains, NJ, is currently defending a case in which the codefendant EP apparently failed to recognize signs and symptoms of a basilar artery stroke in a 34-year-old male.

The patient underwent dental work, returned to his office, and was later found disoriented in the bathroom. "He was taken to the ED within one hour of symptom onset, well within the three-hour window for tPA, if the ER doctor had recognized a possible stroke and triggered the stroke protocol," says Heller.

The EP apparently attributed the patient's slurred speech at presentation to numbness of his lips from dental anesthesia. "The patient's youth and relatively low risk for stroke were also factors in the ER physician's thought process," says Heller.

It also appears the EP did not become concerned when the patient became unable to find

words, and experienced decreasing strength in his arms and legs. "Clearly, those worrisome findings were suggestive of a stroke and were not attributable to dental anesthesia," says Heller.

By the time the EP called a neurologist, it had been more than 4.5 hours since the onset of symptoms, so the patient was no longer a candidate for intravenous tissue plasminogen activator (tPA). He was then transferred to another facility, where a neurosurgeon attempted intraarterial tPA about eight hours after the onset of symptoms.

Unfortunately, there was an extravasation into the brain parenchyma. Therefore, the procedure was stopped, as the neurosurgeon thought it was unsafe to attempt to remove the clot. "This has left the now 37-year-old patient in a 'locked in' syndrome," says Heller. "His only means of communication is through his wife's interpretation of eye signals, and recent use of a computer keyboard which he activates by fixing his eye gaze on specific keys."

Heller says the "take home lesson" for EPs is that any patient who presents with stroke-like symptoms is presumed to be a stroke patient until proven otherwise. In this case, the EP was initially misled by the patient's youth and low risk factors for a stroke.

"He was at low risk, but not at zero risk," says Heller. "This potentially life-threatening condition needed to be ruled in or out in a timely fashion while the optimal treatment was still an option."

In addition, the EP failed to monitor the patient and recognize the patient's worsening condition. "That deterioration was probably the sign which should have alerted the ER physician that a more ominous event was occurring, which required immediate workup and intervention within the window for the optimal treatment of IV tPA," says Heller.

The EP testified in his deposition that he suspected stroke immediately upon the patient's arrival and called consultants. "However, his testimony is contradicted by several consultants who can prove they were not contacted by the EP until over 4.5 hours after the onset of symptoms," says Heller. Here are some other common fact patterns in "missed stroke" claims against EPs:

- When the CT scan came back negative, the EP assumed the diagnosis was benign.

This is probably because the patient did not fit their typical profile of a stroke victim, says Mims. "CT is of little or no help in diagnosing an acute ischemic stroke," he adds. "On standard of care,

these cases are difficult to defend.”

- Plaintiffs had subtle symptoms that mimicked symptoms of a more benign process, such as concussion, dehydration, or benign positional vertigo.

“Cases are easiest to defend when the ED doctor documents his or her suspicion of stroke, and his or her reason for ruling it out,” says Mims.

In one case, the EP considered stroke, though this was not documented, ordered a CT scan, and documented a diagnosis of “vertigo.”

“The patient was discharged, only to be brought back hours later with a full-blown stroke,” says Mims. The EP testified that she thought the condition was due to benign positional vertigo, but never performed a simple positional maneuver that might rule out the diagnosis. “She tried to defend this by arguing that the maneuver might cause discomfort, which, of course, is the intention of the maneuver,” says Mims.

- An accurate and complete history was not taken, and the EP failed to appreciate that the patient’s symptoms were of sudden onset.

For example, a head injury might cause a concussion, and that might result in headache, vomiting, and vertigo. However, if the injury occurred without symptoms, and two hours later the patient has sudden onset of headache, nausea, vomiting, and vertigo, the diagnosis of concussion is less likely.

“It must be recognized that head or neck trauma, or sudden movement of the head — whiplash, for example — should raise the suspicion of stroke in those patients that don’t fit the typical stroke profile,” says Mims.

- EPs failed to activate the stroke team without delay.

The ED’s objective at Primary Stroke Centers is to administer tPA to eligible patients within one hour of arrival. “Yet many ED doctors seem to want to reach a definitive diagnosis before activating the stroke team — with valuable time lost,” says Mims.

Mims has heard EPs testify that they didn’t want to waste resources by activating the stroke team when stroke is not present. “Which question would you rather answer — why you called the stroke team when there wasn’t a stroke, or why you discharged a patient with early signs of stroke who was still eligible for effective therapy?” he asks.

- The EP failed to include stroke on the dif-

ferential for patients with sudden onset of neurological deficits.

If the EP considers stroke, orders a timely CT, and calls for a timely neurological consult, “the ED doctor will have a much more defensible case,” says Mims. ■

## Sources

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## Not Giving tPA? EPs Must Protect Themselves Legally

**T**here is actually surprisingly little the emergency physician (EP) can do to influence the outcome of most stroke cases, according to Marc E. Levsky, MD, a board member of the Walnut Creek, CA-based The Mutual Risk Retention Group, a fellow at Physician Insurers Association of America (PIAA), a Rockville, MD-based insurance trade association, and an EP at Seton Medical Center in Daly City, CA, “but a skilled plaintiff’s attorney or expert can convince the jury otherwise.”

Levsky has seen many plaintiff experts allege that use of tissue plasminogen activator (tPA) could have prevented a patient’s major long-term disability. “Even though this claim is dubious scientifically, juries often buy it,” he says.

One malpractice case involved a man in his 30s who presented to an ED with a seizure. “Seizure is a very unusual presentation of stroke in this age group,” says Levsky. “But after an extensive workup, it was found he had a clot in the vascu-

lar artery.” Even though the patient was ineligible to receive tPA because of the seizure, failure to administer tPA was one of the allegations in the malpractice claim against the EP.

The case settled, mainly because the plaintiff was sympathetic, says Levsky, “even though tPA was completely contraindicated, and it’s also highly questionable that it would have done anything to help the patient.”

Levsky has seen many instances of adverse outcomes from EPs giving tPA to patients, both appropriately and inappropriately, in which patients developed serious bleeding and even died. “These cases could become claims too; however, they seem to do so less frequently,” he says.

If an acute stroke patient has high blood pressure or has a very advanced age, says Levsky, “we know we could do something that can potentially harm the person, and probably won’t help them. But if we don’t do it, we’re much more likely to be sued.”

The EP’s best defense, says Levsky, is to document a thorough discussion in which the patient declined tPA, with the patient’s words in quotes. “Documentation of a refusal is very important in these cases,” he underscores. “Even in cases where the patient might be eligible, or probably isn’t eligible, I still try to document a thorough informed consent process, with refusal of tPA by the patient/family where applicable.”

**Jordan S. Powell, JD**, an attorney at Levin & Perconti in Chicago, IL, recommends that EPs have a “full and frank” discussion with patients and their family about the risks and benefits of tPA.

“Injured patients and family look to file a lawsuit when they have not received answers to their questions, and no remorse or sympathy is shown by the treating physician(s),” he says.

## Will Lawyer Pursue Claim?

“Missed stroke” cases involving ED patients with poor functional outcomes or high levels of disability are typically strong candidates for settlement, says Levsky. “A badly disabled young person would be very influential to a jury, regardless of causation,” he explains.

Levsky says this is partly due to a perception that in medicine, “action is always better than inaction, even if the science is completely lacking. And if the outcome is bad, then the EP gets blamed by default.”

When a plaintiff attorney is deciding whether

to pursue a claim against the EP for a case involving missed stroke, **Gary Mims, JD**, a partner at Sickels, Frei and Mims in Fairfax, VA, says the most important factor is whether timely intervention would have likely altered the patient’s outcome.

For example, if a patient awakens with stroke symptoms that go unrecognized by the EP, that patient likely would not be a candidate for tPA, since the onset of symptoms cannot be determined and the window for intravenous tPA is 4.5 hours.

“Unless there was some other appropriate therapy that would have helped, even with a clear violation of the standard of care, the case would not be pursued by most plaintiff’s lawyers,” says Mims.

It is very important to the EP’s defense to have an onset time of stroke symptoms documented in the medical record, underscores Powell.

If a patient begins to exhibit signs and symptoms of an ischemic stroke in the ED, he says, these cases “are certainly more winnable and ones that doctors should settle. In this situation, there is ample time for appropriate testing, consulting, and treatment if indicated.” ■

## Sources

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## EMR Charting “Creates New Areas of Liability” for EPs

Time-stamped electronic medical record (EMR) entries became the primary focus during a meeting with a patient’s family and their

attorneys at Carilion Clinic in Roanoke, VA, in which concerns were being addressed about a patient's adverse outcome after a procedure performed in the emergency department (ED).

"They were looking at time stamps from the doctor's note, and lining those up with time stamps from the nursing notes, and asking why the patient wasn't managed differently," says **John Burton, MD**, chair of the Department of Emergency Medicine.

Burton then had to explain to the family and attorney that time stamps in the EMR don't necessarily indicate when something was done. "We might enter something in the EMR when we actually did it 15 minutes ago," he says.

Time-stamped EMR entries can cause plaintiff attorneys to draw inaccurate conclusions about care provided in the ED, says Burton, "but regardless, it's a very powerful tool to really ratchet down on the provider as to what we knew, and when we knew it."

Emergency physicians (EPs) face unique risks involving time-stamped EMR documentation, especially in rural hospitals, says **Anjali B. Dooley, JD**, a health care attorney in St. Louis, MO. "An ER physician can only document after stabilizing or treating the patient," she says — which could result in misconceptions about when something was done.

Metadata in EMRs "creates a huge database of almost unintelligible information, but it's also all discoverable, and it can be misconstrued as to what it means," says **Kevin Klauer, DO, EJD**, chief medical officer for Emergency Medicine Physicians in Canton, OH. He adds that EMRs used in EDs "create new areas of liability and complicate existing areas of liability."

The ED's EMR audit trail tells plaintiff lawyers, years after the care was rendered, who accessed the patient's chart, when and where the chart was accessed, and what type of information the provider input or reviewed, says **Marcie A. Courtney, JD**, an associate at Post & Schell in Philadelphia, PA.

"EMR audit trails are typically produced in discovery to all counsel," she notes. These can be used to challenge the accuracy of the defendant EP.

An EP may testify at a deposition that the chest X-ray results were not available during his shift, for example. "The EP will lack credibility before a jury when the audit trail demonstrates that the test results were available 30 minutes before the physician wrote an entry in the patient's chart,

and therefore should have been reviewed," says Courtney.

## Less Opportunity to Catch Errors

Since the EMR makes it easier for an EP to enter information quickly into the chart, more mistakes in documentation are likely to occur, says Courtney. "Items may be unintentionally clicked on, or may be accidentally overlooked," she says.

For instance, a patient's neurological exam may be abnormal due to impaired speech. However, in trying to quickly document findings, the EP might accidentally click another choice on the drop-down screen, instead of "impaired speech." "Delays in treatment or incorrect treatment may be the result of this type of documentation error," Courtney says.

EMRs have made some ED processes less transparent, in terms of identifying mistakes that could harm patients, according to Klauer. It takes EPs longer to do order entry and documentation, for instance, "but as far as delivery of care, pressing 'enter' sends an order much more quickly than handing it to a unit secretary and then a nurse," he says. "In addition, putting the computer between providers has reduced communication."

Similarly, Klauer has observed EPs inadvertently select the wrong medication without realizing the error or determining how it occurred. "Either they clicked on the wrong area, the mouse has a glitch, or the computer screen jumped," he says. "We have had cases reflecting that issue."

Previously, EPs quickly realized that they picked up the wrong paper chart after reading through it. If EPs go into the wrong patient record in the EMR, however, they are less likely to catch the mistake since all screens appear the same.

Klauer says that in his experience, EPs often click through the clinical decision support EMR questions simply to get through the chart in order to get to the next patient.

"This validates the questions being asked, even if we don't think they're important," he says. "In doing so, we create a false standard of care that it's the right way of doing things." He offers these recommendations for EPs to reduce legal risks involving EMR charting:

- EPs should avoid overdocumentation due to grouping physical examination items together.

"You need to be very mindful of overdocumentation. Only document what you've done," says Klauer.

If it appears as though something is included in a group of items that wasn't done by the EP, the EP "either needs to have it removed, or reflect that you can't remove it but that's not what you did," says Klauer.

- EPs should advocate for maintaining a medical decision-making section in the EMR.

The EP can then truthfully state something to this effect, says Klauer: "The only thing in the EMR that are my actual words is this section. This is where I describe what is happening with this case. The rest is difficult to read. Although I agree with the statements made, I have to point and click within the confines of the system, except for this area."

- If there are data that haven't returned for a patient who left the ED because he or she was admitted, discharged, or left without being seen, EPs must ensure there is a mechanism to identify this and be sure the data are reviewed.

"What I've seen happen is that if a patient leaves, they're removed from the EMR tracking board," says Klauer. "So therefore, no one is checking those results."

EDs should have policies that don't allow patients to be removed from a tracking board in the EMR until pending results come back and they are reviewed, advises Klauer.

"There are cases out there of people with positive results that were undetected, who had bad outcomes because of it," says Klauer. One such case was well-publicized in the lay press, involving a child who died after being discharged from a New York ED. One of the issues in this case was that the patient's elevated white blood cell count didn't post into the EMR as resulted data until the patient had already left the ED.

"Did the EMR hide that? Well, if you are printing out lab data and putting it on the chart like we used to, maybe it would have been easier [for the EP to realize that the results hadn't been returned]," says Klauer.

One solution is for the EMR to alert EPs of outstanding test results that haven't come back and/or haven't been reviewed yet, and possibly not allow EPs to disposition the case without acknowledging those results.

"Even if that lab test wouldn't have changed your medical decision-making, the plaintiff's expert will argue otherwise," says Klauer. The EP will then have to answer the question, "Why did you order a test result if you didn't care about the result?" "That is never going to be a defensible position to be in," says Klauer.

## EPs Face Risks of Fraud

A January 2014 report from the Office of the Inspector General (OIG), *CMS and its Contractors Have Adopted Few Program Integrity Practices to Address Vulnerabilities in EHRs*, warns that certain EHR documentation features, if poorly designed or used inappropriately, can result in poor data quality or fraud.

"The Department of Health and Human Services has authorized them to pursue this fraud," notes Klauer. (To view the report, go to <http://1.usa.gov/1afAtJE>.)

"What is amazing to me is that the government pushed meaningful use, but when costs increase because there is greater charge capture, they say, 'This is fraud and we are going to crack down on you,'" says Klauer.

The report stated that the two most common electronic health record (EHR) documentation practices used to commit fraud were copy-and-paste and overdocumentation. Klauer says both of these practices put EPs at risk for allegations of billing fraud.

With overdocumentation, he says, "they are very clear. If you are adding things to the record in macro statements and drop-down boxes that you didn't actually do and the claim is submitted, that's fraud."

Similarly, metadata can show that an EP copied part of a previous record and pasted it into the current record. If a patient returns to the ED several days after a prior visit, both times with the complaint of abdominal pain, the EP might move the physical exam from the previous visit to the current record because it's unchanged, for instance.

"The OIG says you need to verify the accuracy of that information," he says. "But it's going to be very difficult to prove that you verified the accuracy, as opposed to just cutting and pasting the old data, if you copied and pasted a portion of the old record. When it comes down to it, it's not a safe practice."

If the EMR is set up to auto-populate the patient's medications from a previous visit, "that's probably OK," says Klauer.

However, if the EP goes in and looks at the record, pastes it in the new record, and then bills that chart, "it is very likely they'll see this as fraud unless you can defend it, which I think will be very difficult," says Klauer. ■

## Sources

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After completing this activity, participants will be able to:

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

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## CNE/CME QUESTIONS

1. Which is true regarding claims against emergency physicians (EPs) involving allegations of missed or delayed diagnosis of stroke, according to **Gary Mims**, JD?
  - A. Stroke is a likely cause of symptoms of vomiting, headache, and vertigo, even in a young, healthy patient.
  - B. The EP can rely on a negative CT scan as an indication that the diagnosis is benign.

- C. The standard of care is not breached if the EP rules out an acute ischemic stroke based on a negative CT scan.
  - D. Cases are easiest to defend when the EP documents his or her suspicion of stroke, and his or her reason for ruling it out.
2. Which is recommended to make claims alleging missed stroke more defensible, according to **Jordan S. Powell, JD?**
- A. If tPA is not administered, EPs should not specify that it was considered and why it was ruled out in their documentation.
  - B. EPs should reach a definitive diagnosis before activating the stroke team.
  - C. EPs should put stroke on their differential anytime a patient has sudden onset of neurological deficits.
  - D. EPs should not discuss the specifics as to why tPA was not administered with patients and/or family.
3. Which is recommended to reduce legal risks involving electronic medical record charting, according to **Kevin Klauer, DO, EJD?**
- A. EPs may "copy and paste" physical exam information from a previous record if it is unchanged as long as the patient has the same chief complaint.
  - B. EPs should not typically utilize the medical decision-making section in the EMR, as this can result in allegations of overdocumentation.
  - C. If data haven't returned for a patient who left the ED, there must be a mechanism in place to be sure this is identified and the results reviewed.
  - D. When a patient is discharged or admitted, he or she should be immediately removed from the EMR tracking board.

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