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August 2014
Vol. 25 • No. 8 • Pages 85-96

Recent Malpractice Cases: Beware of Syncope and Stroke!

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It is important to be aware of emergency department (ED) cases and situations that lead to lawsuits in order to avoid repeating errors and reduce personal liability. This issue highlights some recent cases that involve syncope and stroke.

Case 1: Syncope and Anticoagulation

On the evening of June 8, 2011, Mr. Anthony Musco, age 64, experienced a syncopal event and hit his head on the floor. He had no known past medical history. EMS were called to the scene. They performed an EKG upon arrival that demonstrated atrial fibrillation, which soon converted into normal sinus rhythm. Upon arrival to the emergency department (ED) at Lakeland Regional Medical Center, he received a CT of his head, which demonstrated no acute injury. The patient was then admitted to the hospital for further observation and evaluation. The primary inpatient team started the patient on enoxaparin every 12 hours as a prophylaxis against blood clots. While in the hospital, the patient underwent extensive testing for a possible cause of the syncope and new-onset atrial fibrillation. The inpatient cardiologist, Dr. Canto, was consulted by the primary team for new-onset atrial fibrillation. The cardiologist agreed with the primary team's treatment plan, and no changes were made to his treatment plan. Three days after the initial syncopal event, the patient experienced a massive brain bleed and sudden clinical decline. The patient went into a coma and died 10 days later.

At trial, the plaintiff claimed that Dr. Canto, the cardiologist, should have stopped the enoxaparin due to the risk for delayed brain bleed. They stated that enoxaparin increased the rate at which the bleeding occurred, or was the cause of the bleeding. Per the medical records, the

patient received three doses while in the hospital.

The defense claimed that enoxaparin could not have been the cause of the bleeding, and could have only increased an existing bleed, which was ruled out by the CT scan in the ED. They also stated that enoxaparin was not started until the day after the event. The risk of delayed bleeding due to trauma was remote, and the administration of enoxaparin for prophylaxis was clinically indicated. Dr. Canto supported this claim that enoxaparin was indicated, until all cardiac concerns were eliminated. The plaintiff requested that the jury award a verdict of $10,000,000. The hospital, Lakeland Region Medical Center, and the primary care physician settled for an undisclosed amount. A defense verdict for the cardiologist, Dr. John Canto, was returned.[1]

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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Anticoagulants represent a large portion of the $300-$610 million spent per year on medical professional liability costs associated with injectable medications.[2] In a review of adverse reactions caused by anticoagulants, 24.8% resulted in an increase in bleeding.[3] There is no shortage of cases in medical literature in which physicians have been liable for causing increased amounts of bleeding from anticoagulation. In *Jenkins v. Willis*, a patient with subarachnoid hemorrhage was given enoxaparin, and died shortly afterward.[4] In another case, a patient with right-sided weakness was given enoxaparin after possible stroke and atrial fibrillation, resulting in brain death.[5] Although the physicians in the preceding cases were not held liable for the patients' deaths, the administration of the anticoagulation was linked to adverse outcome. Damages have been awarded to a patient after the administration of the anticoagulation resulted excessive bleeding and, subsequently, permanent disability.[6]

When evaluating a patient with syncope, it is important to screen and recognize that potential head injury has occurred. Many conditions that cause syncope, such as dysrhythmias, pulmonary embolus (PE), and coronary ischemia, will be treated with anticoagulation and worsen traumatic brain injury.

Case 2: Syncope and Pulmonary Embolism (PE)

Mrs. Eliza Miller, age 67, experienced an episode of syncope on October 14, 2011, while at home. On evaluation by emergency medical technicians (EMTs), the patient was asymptomatic. She was brought by emergency medical services (EMS) to the emergency medicine department at Lawnwood Regional Medical Center in Fort Pierce, FL, where she was evaluated by the ED physician. She remained asymptomatic, and the ED physician was not able to determine the cause of syncope. The ED physician later testified that he was highly suspicious that the cause of syncope was due to her extensive cardiac history, but he also considered several other possible causes. Her primary care doctor, Dr. Dawkins, was consulted and the patient was admitted to the hospital. While in the hospital, Mrs. Miller's cardiologist and the on-call neurologist also evaluated the patient. The three physicians could not determine an exact diagnosis despite the numerous studies and tests ordered. Throughout the initial evaluation and diagnosis, the patient remained asymptomatic.

Later that evening at 10:01 p.m., Mrs. Miller experienced another episode of syncope. Subsequently, she continued to decline and experienced cardiac arrest. Despite numerous attempts at resuscitation, Mrs. Miller died shortly after midnight. At the time of autopsy, the cause of death was determined to be a PE that was blocking both pulmonary arteries.

Following Mrs. Miller's death, her husband filed a wrongful death complaint on behalf of her estate against Dr. Dawkins as well as the ED physician and the cardiologist. The ED physician and the cardiologist settled with the plaintiff.[7]

Overall, there is no shortage of medical-legal cases involving the misdiagnosis of PE. One review article analyzed 160 malpractice claims involving PE. Failure of the clinician to anticipate and reduce the chance of PE was the basis for six of the claims.[8] In some cases, the failure of a clinician to diagnose a PE has resulted in awards of hundreds of thousands dollars to the plaintiff. For instance, in *Mabry v. County of Cook*, the patient was complaining of dizziness and dyspnea. She was then treated for an asthma exacerbation and discharged from the ED after a mild decrease in shortness of breath. Several days later, the patient returned to the ED with symptoms of persistent dyspnea and continued asthma exacerbation. Shortly after being admitted, she died from a PE. The plaintiff was awarded more than $500,000.[9] Recognizing the link between syncope and PE has proven to be a challenging medical-legal aspect, and does not always result in a verdict for the plaintiff. For example, in *Edwards v. Alexander*, the patient presented to the ED with syncope and various gastrointestinal (GI) complaints. The patient subsequently died from a pulmonary embolism in the intensive care unit (ICU), but the courts at the time ruled in favor of the defense.[10]

The diagnosis of PE has been proven to be difficult throughout medical literature. Notably, objective testing confirms the diagnosis of pulmonary embolism in only 20% of patients.[11] Classically, PE presents with dyspnea or chest pain. Vital signs, such as tachycardia, tachypnea, low pulse oximetry, or increase in temperature, may be valuable in diagnosis, but have not proven to be reliable. Approximately 5%-8% of patients who present to the ED present with symptoms consistent with syncope, near syncope, or new-onset seizure.[11] Syncope due to PE is caused by a reduction of blood flow in the pulmonary vasculature or by activation of receptors causing bradyarrythmias that lead to reduction of cardiac output.[12] Patients who present asymptomatically make diagnosis challenging for the physician.

It is imperative to consider PE as an etiology in patients presenting to the ED with syncope.

Case 3: Stroke and Consent

Mr. Charles Coulon Jr., age 65, presented by EMS to the East Jefferson General Hospital ED (EJGH) in Metarie, Louisiana. He was aphasic and unable to provide a medical history. However, his wife informed the ED physician, Dr. Terry Creel, that at approximately 10:45 p.m. she was awakened by a loud "thump," whereupon she found her husband lying on the ground in front of a sofa where he had been seated. She noted that he was confused, had slurred speech, and was unable to move his right side. She called 911, and Mr. Coulon was transported to the EJGH, arriving at approximately 11:20 p.m., within 35 minutes of his unwitnessed fall.

Mrs. Coulon relayed to Dr. Creel that Mr. Coulon also had a facial droop, which appeared to improve en route to the ED. Upon arrival, his blood pressure was 145/95. His neurological examination showed a right facial droop and a flaccid right arm, with some slight movement of his right hand. A left cerebral vascular accident (CVA/stroke) was clinically diagnosed.

Dr. Creel ordered a non-contrast head CT scan. The radiologist noted that the CT scan did not show any evidence of hemorrhage, infarction, or discernable trauma. At 11:59 p.m., approximately one hour and 50 minutes after symptom onset, and 40 minutes after arrival in the ED, the radiologist notified Dr. Creel of the CT results.

Although Mr. Coulon's CVA was diagnosed within the three-hour "window" in which tissue plasminogen activator (tPA) should be considered in the treatment of an ischemic CVA, Dr. Creel concluded that he was not a tPA candidate, as his fall was unwitnessed, his facial asymmetry was improving, and he had slight use of his arm. There is a factual dispute as to whether Dr. Creel discussed the possibility of administering tPA with Mrs. Coulon. At deposition, he testified that he offered tPA but she declined, stating that, "I do not want any further harm done to my husband." Mrs. Creel denied that such a conversation had ever transpired. Dr. Creel admittedly failed to document this conversation. At deposition, Dr. Creel admitted that he never specifically

informed her about the benefits and risks of tPA (e.g., the 12% chance of neurologic improvement at three months versus a 6% risk of intercranial hemorrhaging). Because he deemed that Mr. Coulon was not a tPA candidate, Dr. Creel did not consult a neurologist.

At trial, the jury awarded Mr. Coulon $150,000 in damages, but denied future medical expenses. This is clearly a small award that is not consistent with compensating the effects of a missed CVA. During post-trial jury interviews, jury members expressed concerns regarding the issue of informed consent. They were concerned that there was a lack of discussion and clearly no documentation on the chart that Dr. Creel had ever reviewed the risks and benefits of tPA with Mrs. Coulon. Clearly, the jury, via the size of the award, did not think a case was made that tPA should have been unequivocally administered, but were willing to give compensation on the undocumented or lack of informed discussion on the administration of tPA.[13]

Multiple other recent court cases have mandated that informed consent is warranted when discussing treatment, admission versus discharge, and even test ordering in stroke-related conditions. In one case, a patient was discharged for outpatient treatment of TIA and had a CVA.[14] In another case, a patient discharged with a diagnosis of Bell's palsy was not informed that CVA was in the differential diagnosis, and that a CT scan was a test consideration.[15]

There is no doubt that issues regarding tPA administration frequently arise in ED litigation. In a recent review of ED legal malpractice suits, seven legal databases were used to examine lawsuits from the ED associated with tPA and stroke. Thirty-three cases were found involving tPA ischemic stroke therapy. In 29 (88%) of these cases, patient injury was claimed to have resulted from failure to treat with tPA. Emergency physicians were the most common physician defendants. Defendants prevailed in 21 (64%) cases, and among the 12 with results favorable to the plaintiff, 10 (83%) involved failure to treat and two (17%) claimed injury from treatment with tPA.[16] The study noted that more lawsuits are filed for failure to give tPA in ED stroke patients rather than complications from its administration.

Case 4: Stroke Mimics

In a recently settled Kentucky case, *Sparks v Bokhari*, a 43-year-old woman was celebrating on Christmas Eve with her family. There was no family discord or stress. She was witnessed to suddenly fall to the ground. The family noted that she could not speak and was unable to use her right arm at approximately 9:30 p.m. They brought her immediately to the ED. Upon arrival, she was evaluated by Dr. Bokhari at 10 p.m. A CT scan of the brain was performed and read by the radiologist as normal at 10:48 p.m. Nursing notes commented on the patient's "unwillingness" to communicate and also that she moved her extremities when the family was not present. The physician failed to document a neurologic exam on the chart. At one point, the family testified that Dr. Bokhari stated, "Your daughter is having a nervous breakdown because of how you raised her." Mrs. Sparks was admitted to the hospitalist with a diagnosis of conversion disorder. No neurologist was consulted, and administration of tPA was not considered. The next morning, a repeat CT scan revealed a large left middle cerebral artery infarct. The patient was left with dense motor and speech deficits. The case was settled for an undisclosed sum.[17]

It is imperative that ED providers be aware that other illnesses may mimic a stroke. A study looked at what other diagnoses are often labeled as CVA. In 65 cases of definite stroke mimic and 44 cases that were likely mimics, the following were the most common etiologies: Seizure accounted for 21.1 %, followed by sepsis (12.8%), toxic/metabolic (11.0%), syncope (9.2%), confusional state (6.4%), vestibular problems (6.4%), mono-neuropathy (5.5%), and migraine (2.8%).[18]

Conversion orders often present with neurologic-type symptoms. These include: non-epileptic seizures, weakness and paralysis, movement disorders, speech disturbances, globus sensation, sensory complaints, visual symptoms, and cognitive symptoms.[7] The ED provider must be very cautious in making this diagnosis in the ED. Between 2% and 50% of patients diagnosed with conversion disorders later develop severe organic disease. One study of 85 patients with the diagnosis of conversion disorder found 12% had neurologic disease.[19] ■

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Admitting MDs Likely to Point Finger at Codefendant EP

But responding in kind could keep EP in case

A 19-year-old presented to an emergency department (ED) one hour after suddenly slumping over and having difficulty speaking. The emergency physician (EP) ordered a CT scan, which the EP read as a small infarct in the thalamus of indeterminate age. No neurology consult was called.

The patient was admitted by the hospitalist, who did not come to examine the patient. The following morning, angiography revealed basilar artery occlusion. The patient suffered a severe brainstem injury, now requires 24-hour-care, and uses a wheelchair.

The resulting malpractice claim alleged delayed diagnosis due to the EP's failure to obtain a neurology consult and angiogram, and failure to administer tissue plasminogen activator (tPA).[1]

The EP claimed that the neurologist didn't return his call. The hospitalist claimed he was told that there was no neurologist available and that the radiologist didn't read the CT scan properly.

In 2013, a jury returned a verdict of $38 million, finding the hospitalist 40% negligent and the EP and radiologist each 30% negligent. "Lawyers love it when three doctors are all blaming the other because then someone is going to pay," says **Gregory P. Moore**, MD, JD, an attending EP at Madigan Army Medical Center in Tacoma, WA.

When malpractice claims name both the admitting physician and EP, each defendant typically claims that the other physician was aware of critical facts, says Moore, and denies that they were given the information.

"Lateraling care to a hospitalist doesn't extract you from later liability, if you had an opportunity to make an impact on the outcome during your care," warns Moore. He recommends that EPs clearly document key facts, including sign-off of care to the hospitalist.

"Provide accurate and thorough communication, and then document it," advises Moore. "It is also advisable to tell the patient and document, 'I have transferred your care to the hospital doctor. He has agreed to do X and Y.'"

It is quite common for admitting physicians to claim that the EP steered the admitting physician down the wrong path, or that the EP came to a

diagnosis without completely ruling out other possible diagnoses on the differential, says **Ryan M. Shuirman**, JD, an attorney at Yates, McLamb & Weyher in Raleigh, NC.

"I have had two recent cases where the plaintiff tried to exploit tension [between the EP and admitting physician], and absolutely pointed the finger at the emergency physician for starting the train down the wrong track," says Shuirman. This occurs even in claims in which the EP used good clinical judgment in reaching a diagnosis. "We can typically handle such a retrospective blaming by emphasizing the admitting physician's independent obligation to do his or her own exam and use his or her own independent judgment," says Shuirman.

Finger-pointing Complicates Defense

EPs tempted to point fingers should remember that the plaintiff's lawyer likely has an expert who is willing to criticize the "innocent" EP, says Shuirman.

"There is often a perceived short-sighted benefit to accusing codefendants of malpractice while maintaining one's 'innocence,'" says Shuirman. However, if the EP defendant takes the position that the admitting physician was at fault, "this almost universally makes things more difficult for all defendants in a case," he warns.

The EP's willingness to turn on the other defendants in a case gives the plaintiff's lawyer an added incentive to keep the EP in the case. "The plaintiff's lawyer can then sit back and allow the defendants to argue among themselves about who is at fault, with a near certainty that a jury will find one defendant, if not all defendants, liable in the end," says Shuirman.

Scott T. Heller, Esq., an attorney with Reiseman, Rosenberg, Jacobs & Heller in Morris Plains, NJ, says "throwing a codefendant 'under the bus' is generally a bad idea. If there is any theory under which a codefendant can retaliate against the EP, they will generally do so."

This sets up a "finger-pointing contest" in which only the plaintiff wins, says Heller, adding that factual issues regarding who was at fault — the EP, the admitting physician, or both — are reserved for juries. "This will also likely guarantee the [emergency physician] will remain in the case as a defendant," he says. ■

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Should Med/Mal Claim Be Settled or Defended?

Things are rarely as they appear early in litigation

Upon learning he was being sued, one emergency physician (EP) was determined to defend the claim vigorously, until he learned that one of the experts on the plaintiff's side happened to be one of his professors from medical school. The expert stated in a deposition that what the EP did was contrary to everything he was taught in medical school.

"You might have an EP who, right out of the gate, says, 'I did nothing wrong, and hell will freeze over before I will ever consent to settle,'" says **David P. Sousa**, JD, COO, and general counsel at Medical Mutual Insurance Co. of North Carolina in Raleigh.

The facts of the case may convince that EP that settlement is the best option, just as EPs anticipating a quick settlement sometimes decide they do want to go to court after additional facts come to light. "They may be thinking early on, 'I've got to settle because I screwed up,'" says Sousa. "But when you flush out all of the evidence, including all of the clinical information from other subsequent treating doctors — often, when they see all that, it can change their mind."

One EP learned, for example, that a delay in getting a patient to the cardiac catheterization lab wouldn't have changed the outcome due to the patient's previous cardiac history.

Since things are rarely as they appear initially

when a malpractice suit involving ED care is filed, good decisions about whether to settle or defend the case can often be made only after the litigation process plays out, advises Sousa.

"Until you get the prior clinical history, which the ED rarely has, and figure out exactly what happened after the patient's ED visit, it would be like trying to complete a jigsaw puzzle that was missing pieces," he says.

Not Always EP's Choice

Most malpractice insurance contracts covering EPs have a "consent to settle" provision, meaning that the insurance company cannot settle the case without the EP's permission to do so.

"There are situations where the EP really wants to defend the case but the insurance company feels that a defense before a jury is highly unlikely, and the jury verdict range [is] extremely high," says Sousa. Many insurance carriers have a provision that allows them to effectively "overrule" the "consent to settle" provision if the EP has no material facts on his or her side that would allow the case to be successfully defended.

"It is rare that an insurance company would ever invoke that trump card," says Sousa. "There's usually going to be some merit to defending a case, even though it might be an uphill battle." If the insurance company believes the case is defensible, they don't need the EP's permission to proceed with that defense.

Maintaining control over the decision to settle is "highly desirable for a physician, especially in light of the fact that settlement results in mandatory reporting to the National Practitioner Data Bank," says **David S. Waxman**, JD, an attorney with Arnstein & Lehr in Chicago, IL.

"The decision to settle is obviously a critical one, which can have, on occasion, significant implications for an ER physician," says Waxman.

EPs often want to defend themselves to avoid the negative impacts of a settlement or a jury verdict on their reputation, on their ability to obtain and hold privileges at a hospital, and to be an approved provider by insurance companies, says Sousa.

"Authority for making the decision to settle claims is commonly addressed in employment contracts," notes Waxman. EPs considering the benefits of a particular employment arrangement must understand that certain provisions could disenfranchise them in the midst of malpractice litigation, he warns.

"Simply put, the risk-management interests of a corporate employer are not always commensurate with the career needs of an ER physician," he says.

Factors "Make or Break" Case

If the EP feels strongly that a malpractice claim should be defended, and at least one expert witness will support the care they gave, says Sousa, then Medical Mutual will do everything in its power to defend that EP.

"But you hate going in with less than a full deck," says Sousa. "Smart people who participate in litigation on a regular basis know that good facts make for the best outcomes. If you do not have good facts, the chances of prevailing go down astonishingly quickly." Here are the three factors that Sousa says "will make or break" a malpractice claim against an EP:

- Does the medical record support the EP's decision process in doing what he or she did when the patient presented?
- Is there expert witness support?

"This is clearly important as to whether you are going to be able to defend the EP in court," says Sousa.

- Will the EP be a good witness testifying on his or her own behalf?

"This is the top of the list in every single case," says Sousa. "If the EP is believable and likable, then the EP is going to win the vast majority of the time."

Even if the EP uses poor judgment, or his or her clinical skills are somewhat lacking, the EP is likely to prevail if he or she is a good witness, and there is at least one expert and documentation to support the care provided, says Sousa.

"In the absence of any one of those things, your chances of being able to defend the ER doctor go down significantly," says Sousa. ■

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Disclosure of Errors in ED Setting: Patients Typically Grateful

Claims typically don't result, or are quickly resolved

An EKG was misread by an emergency physician (EP), and the patient had an adverse outcome as a result. The patient's family was contacted, and a face-to-face meeting was arranged with the hospital, the emergency department (ED) medical director, and the EP who made the error, who were all in attendance.

"We explained to the family that there was a misread, how it occurred, and why it occurred," says **Ryan Domengeaux**, JD, general counsel for Schumacher Group, a Lafayette, LA-based healthcare resource company that partners with emergency medicine providers to staff and manage EDs.

The family was previously unaware of the error. "They were very appreciative of our candor, and there was no claim that resulted from it," he reports. This is a typical reaction when patients and families are told about a mistake that occurred in the ED, even if the patient was harmed, according to Domengeaux.

Schumacher Group has had an early disclosure and compensation model in place for many years. "We manage adverse events and claims with honesty, transparency, and humility," says Domengeaux. "Timely communication to a patient or their family about an error in the ED setting is our obligation. I consider it to be as much about patient care as administering actual clinical treatment."

Plaintiff Attorneys Are Skeptical

Plaintiff attorneys are usually skeptical that the EP and the hospital will truly be forthcoming about the care provided. "The truth is, they are looking for a fight. That's what they've always gotten with insurance carriers and providers," Domengeaux says. "Everybody keeping their cards close to the vest is what everybody's experienced."

In the small number of cases in which disclosure has ultimately resulted in a malpractice claim, there has been little lag time between notification of the claim and settlement or resolution, however.

"When we offer the plaintiff attorney an olive branch, it's amazing to see their transformation," he says. "There is a less of a fight and more of a path to resolution."

If Domengeaux encounters an EP who is reluctant to disclose errors, he reminds him or her that telling someone a mistake was made doesn't mean that negligence occurred. "The expectation in the legal world is not that doctors be perfect; it's that they act reasonably and with prudence," he underscores.

Schumacher Group averages about one claim per 38,000 ED visits. In the years since the disclosure program was implemented, annual visits doubled from about two million to four million, while the number of claims has remained stable. "In that time, we have seen absolutely no indication of any increase in claims volume attributable to our practice of early disclosure, of being candid and forthright with our patients and their families when it comes to owning up to a mistake," says Domengeaux.

Even in cases in which patients harmed by an error are compensated, the process is streamlined. "Every situation that I've experienced, both in claims management and early disclosure, has always been very favorable when it comes to discussing compensation, if that is an issue ultimately raised," says Domengeaux.

Few Patients Expect Compensation

Robert B. Takla, MD, MBA, FACEP, medical director and chief of the Emergency Center at St. John Hospital and Medical Center in Detroit, MI, has disclosed mistakes to patients and family for many years. When he does so, individuals are typically grateful.

Disclosure has also become an organizationwide focus for Ascension Health in the last several years, with an expectation for practitioners to "communicate openly and resolve early (CORE)." EPs more often disclose errors to patients and family.

"It's the right thing to do. If we made a mistake, we need to accept responsibility and see how we can fix it," Takla says.

Takla acknowledges that it's possible that disclosing an error could lead to a lawsuit that otherwise wouldn't have occurred. "You can't predict when it's going to lead to identifying a lawsuit that nobody would have even known about," he says. "We do this because it's the right thing to do. You can't ask, 'Would we have been better off financially if we just kept our mouth closed?'"

Takla says that in his experience, however, even when all the elements necessary for a malpractice

claim are present, "usually when you disclose, it's resolved before even going for a summons and complaint, and usually it's in everybody's best interest."

Takla routinely discloses even mistakes that didn't cause harm, such as an unnecessary blood draw or steroid dose intended for another patient. In this case, Takla tells the patient, "Mrs. Smith, I apologize. You were given a medication that was meant for somebody else. It's a very safe medication, and I don't expect any adverse outcomes whatsoever, but I just wanted to make you aware. I am genuinely sorry for this."

Some EPs still aren't comfortable disclosing mistakes, in part because they don't have a long-term relationship with their patients. "The ER is a high-litigation world," says Takla. "The pace and the uncertainty makes it a more error-prone environment. There is constant workflow interruption."

EPs usually expect that most patients will sue if they have the opportunity, adds Takla. "We deal with enough difficult personalities that are here with ulterior motives, whether for litigation support or because they are drug-seeking or wanting time off work," he says. "It is easy for us to get a jaded perspective."

The vast majority of patients have been very understanding, however, and few expect any type of compensation after an error is disclosed. "Usually what it does is tells the patient that we are human and fallible, but we are also willing to own up to our mistakes and minimize them from recurring," says Takla.

Facts Are Learned First

The EP's apology has to be sincere and genuine, emphasizes Takla. "I really try to get the facts first when I can and disclose as soon as possible. But I treat each situation on a case-by-case basis," he says.

If an error occurs but all the facts aren't known, Takla tells the patient, "Please give me an opportunity to get all the facts. I promise to get back to you in the next 24 hours."

"Once all the facts are known, I like to have a team approach, which may or may not involve risk management," says Takla. In some cases, he has contacted patients by phone if the error was discovered after discharge. "Sometimes they knew something didn't happen correctly, and are surprised that we reached out to them," he reports.

Schumacher Group typically completes a peer-review process before the discussion with the patient occurs. This gives EPs a chance to learn the facts before speaking with the patient or family. "If we rush to have a disclosure and then find out we were wrong, then we start to impugn our credibility," Domengeaux explains.

Patients are told upfront that it will take several weeks to review the care provided, but are promised that they will get an honest explanation at that point.

"There's been times when our providers, unbeknownst to us, have reached out to the patients or family, which is not optimal, but still acceptable," notes Domengeaux.

However, even in cases in which EPs have done so, claims typically don't result. One EP wrote a letter to a family member stating that he made a mistake and should have ordered a diagnostic test that could have saved the patient's life. "He basically fell on his sword and said, 'I'm so sorry about this. I'm going to live with this the rest of my life,'" Domengeaux says. No malpractice claim resulted. "Instead of being polarizing, it had a healing and cathartic effect for everyone involved," he says. "What patients really want is honesty, and that is what we give them."

Domengeaux starts by telling patients, family, and attorneys, "If you choose to use our honesty against us, we can't stop you from doing that. But it would be a shame for us both if that occurred."

"The beauty in the process is that I've just never seen that happen," he says. "The fear is that if you're honest with people, it's going to generate more claims. The reality is, the more honest and objective we are, the more positive the outcome."

Without transparency, patients may feel they need to sue EPs simply to learn the facts of what happened. "They want to get to the truth, as opposed to getting to money," says Domengeaux. "We underestimate the ability of a patient and their family to deal with the truth, and we shouldn't." ■

Sources

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UMHS' EDs Seeing Fewer Malpractice Claims

Events identified and disclosed proactively

Malpractice claims involving care provided at the University of Michigan Health System in Ann Arbor's three emergency departments (EDs) decreased by about half in the past decade, after a disclosure, apology, and compensation program was implemented, estimates **Richard C. Boothman**, JD, executive director for clinical safety and chief risk officer. Legal expenses and open-to-close time for claims were cut by half organizationwide during that period.[1]

"Combining all sites, we've had a roughly 50% decrease in emergency room claims, from a peak in 2000 to 2011, which is the last reliable year, given generally a two-year statute of limitations," says Boothman.

However, the ED setting "does present some interesting challenges" for disclosure of medical errors, reports Boothman. "ED docs see patients in tiny vignettes of those patients' lives, and always when the patient is under stress and distress," says Boothman. Rarely is there much of a relationship to provide a platform for disclosures of errors. "Charting is often skimpy compared with less-acute clinical settings and specific memories on the caregivers' parts years later are rare," adds Boothman.

These factors exacerbate the normal challenges of error-recognition and disclosure in the ED, compared with almost every other clinical environment, according to Boothman. Here are some of the unique challenges of error disclosure in the ED setting, based on UMHS's experience:

• It often takes emergency physicians (EPs) longer to hear about errors that have harmed patients.

Often, when a mistake injures an ED patient, EPs don't find out about it right away, in part because patients don't always return to the same ED.

"We've greatly increased our ability to recognize mistakes in a very timely way," says Boothman. "But still, the ED mistakes often come to us second-hand and in a delayed way, from other health care providers and lawyers."

• The disclosure tends to take longer.

The process requires the team to recognize the difference between "reasonable care under the circumstances" and a medical error, defined as "unreasonable care under the circumstances," says Boothman.

"It often takes us a longer time to reach a point where we are confident of our grasp on the facts," he explains.

For all disclosures, he says, it's always important first to listen to the patient before reaching any conclusions. "But the ED cases seem to entail even more 'back and forth' as we try to ensure that we are completely confident in our conclusions before trying any disclosures or explanations," says Boothman.

• Disclosures also tend to be done more often by a member of the Office of Clinical Safety (formerly Risk Management) than by the EP involved.

"The choice of who does disclosures is always tailored to the situation," says Boothman. Some patients don't want to see their doctors again, and some doctors simply aren't temperamentally fit for it, despite lots of coaching.

"But the ED cases seem, more than most others, to involve an institutional representative, not just the physician involved," says Boothman. This is due in part to lack of a long-term relationship between the EP and the patient, and also the fact that most mistakes made in the ED are process-related and involve multiple providers.

Still, UMHS has been very successful with ED disclosures when patients feel aggrieved or a lawyer is threatening a claim, says Boothman.

In one case, a patient presented with a pain in his leg, which was later diagnosed as a sarcoma. "The claim was that the ED doc should have made the diagnosis," says Boothman. The patient was represented by an attorney, but no lawsuit was filed. A careful, thorough conversation with the patient and family helped them understand these points:

• That diagnoses sometimes take time to manifest themselves;

• That the EP has only a small window of time to make the diagnosis, which is not always possible with scant or early information, or to provide an appropriate referral, or admit the patient to the hospital.

Many patients do not understand the limited role that EPs play. "We've had very good luck helping patients understand that clairvoyance is not the standard of care for an emergency medicine physician," says Boothman. ■

REFERENCE
1. Boothman RC, Imhoff SJ, Campbell DA. Nurturing a culture of patient safety and achieving lower malpractice risk through disclosure: Lessons learned and future directions. *Front Health Serv Manage* 2012;28:13-28.

Source

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CNE/CME OBJECTIVES

After completing this activity, participants will be able to:
1. Identify legal issues related to emergency medicine practice;
2. Explain how the legal issues related to emergency medicine practice affect nurses, physicians, legal counsel, management, and patients; and
3. Integrate practical solutions to reduce risk into daily practice. ■

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CNE/CME QUESTIONS

1. Which is recommended regarding malpractice claims naming both the emergency physician (EP) and the admitting physician, according to **Scott T. Heller**, Esq?
   A. EPs should never not inform patients directly that their care was transferred to the hospitalist.

B. It is not advisable for EPs to document that the patient was signed off to the hospitalist.
C. Factual issues regarding who was at fault are reserved for juries.
D. EPs should always take the position that the admitting physician was at fault, as this makes it more likely the EP will be dismissed.

2. Which is true regarding malpractice claims involving admitted patients, according to **Gregory P. Moore**, MD, JD?
A. When malpractice claims name both the admitting physician and EP, only one defendant can ultimately be held liable.
B. The EP cannot be held liable as long as he or she clearly documents that the patient was signed out to a hospitalist.
C. The admitting physician has no obligation to do his or her own independent examination of a patient previously examined by the EP.
D. Signing out the patient to a hospitalist doesn't protect the EP from subsequent liability.

3. Which is true regarding the decision to settle or defend a malpractice claim against the EP, according to **David P. Sousa**, JD?
A. EPs should always make the final decision as early in the process as possible.
B. Most malpractice insurance contracts have provisions stating that the case cannot be settled without the EP's consent.
C. Insurance carriers often overrule the "consent to settle" provision, even if the case can clearly be successfully defended.
D. Insurance companies always need the EP's permission to defend a claim.

4. Which is true regarding Schumacher Group's experience with disclosure of medical errors that occurred in the ED setting?
A. Malpractice claims typically result if patients were previously unaware of the error.
B. Plaintiff attorneys typically refuse to resolve cases in a timely manner.
C. A higher percentage of claims are resulting in protracted litigation.
D. In the small number of cases in which disclosure has resulted in a claim, there has been little lag time between notification of the claim and settlement or resolution.