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Successful Claims Against EPs Involving Abnormal Findings After Patient Left ED

No process to reconcile inconsistent reports

A recent malpractice claim involved a patient who presented to an emergency department (ED) with severe abdominal pain for which abdominal and pelvic CT scans were ordered by the emergency physician (EP). "The radiologist verbally advised the EP that the patient had diverticulitis. However, the written report also included findings of free air and a perforated colon," says **Brenda C. Tuck**, RN, MSN, CPHRM, a senior risk resource advisor in ProAssurance Companies' Washington, DC, office.

The patient had been discharged from the ED before the written report was available, and no one from the hospital contacted the patient with an update. He presented to a second hospital three days later, where he was diagnosed with sigmoid diverticulitis with contained perforation, a pericolonic abscess, and diffuse ileus requiring a sigmoid colectomy with colostomy and Hartmann's pouch.

"The hospital failed to have a policy in place to reconcile inconsistencies between verbal and written radiology reports," says Tuck. "This delayed the diagnosing and surgical repair of the perforated colon, resulting in the development of an infection."

In a claim with a similar fact pattern, a patient presented to the ED with complaints of weakness and dizziness. He reported undergoing a coronary artery bypass graft approximately three weeks prior to the ED visit, says **James S. Keeler**, MEd, RN, ARM, CPHRM, a senior risk resource advisor in ProAssurance's Richmond, VA, office. A portable X-ray was normal, and a CT was ordered to rule out subdural hematoma.

"The EP says he went to the radiology department and received a verbal interpretation of 'no acute changes,' which he documented on the ER record, and discharged the patient," says Keeler.

The preliminary, handwritten, untimed report by the radiologist iden-

tified a 2 cm lesion near the pituitary midline. "It is unknown when this report was on the chart and available to the EP," says Keeler. "The hospital ED quality analysis said at the time of this event, a procedure for radiology report discrepancies was in effect for plain films but not CT scans."

Over several years, the patient developed significant vision problems and was ultimately diagnosed with ischemic optic neuropathy and permanent vision loss. "Not until over three years after the initial ED visit did an ophthalmologist order a CT scan, and identified the pituitary tumor, with a referral to neurosurgery and eventual transsphenoidal hypophysectomy," Keeler says.

The EP did not obtain a report from radiology prior to discharging the patient, and the hospital did not follow up on the abnormal radiology results.

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"All subsequent treating physicians indicated the pituitary tumor caused the vision loss, and if diagnosed earlier, the patient could have been monitored and operated on sooner, preserving some of his vision," Keeler says.

Pressure to Discharge Quickly

A recent malpractice claim involved the EP sending a pregnant patient home before the result of a urinalysis came back. The patient was never informed that the result was positive for infection, and 48 hours later, delivered twins at home. "The final diagnosis was preterm labor due to pyelonephritis — a complication of a bladder infection that should have been diagnosed and treated two days earlier," says **Stephen A. Barnes**, MD, JD, an attorney at McGehee Chang Barnes Landgraf in Houston, TX. "The ED physician was sued and settled."

In another case, a pneumonia patient was discharged from the ED before a CT scan of the chest came back showing a massive pleural effusion and mediastinal shift. "The patient was not contacted until hours later, and the patient was now too weak to return," says Barnes. "Additional hours were lost attempting to get the patient to the ED by ambulance. On arrival, the patient coded and later died."

EPs are under pressure from administrators to discharge patients as quickly as possible, says Barnes, "but it is never a good idea to save an hour or two by discharging a patient with pending test results."

The majority of EDs simply have no infrastructure available to ensure follow up of such test results, says Barnes, or to answer these questions:

- Who will contact the patient when the results come back?
- What if the patient does not answer or respond?
- If the patient needs a prescription or other therapeutic intervention, which physician will be responsible for providing such care?

"While these are all questions that are very important if one discharges a patient with pending test results, they are made absolutely irrelevant if the emergency physician properly insists on complete data prior to discharging a patient," says Barnes.

To avoid "failure to follow up" claims, says Barnes, EPs "should trust no one regarding follow up, because the jury will believe that you should have trusted no one." EPs can consider these prac-

tices to avoid claims involving abnormal findings reported after the patient leaves the ED:

• ED staff and radiologists should be very familiar with all hospital policies involving reconciliation of inconsistencies between verbal and written radiology reports.

"Frequently held team meetings with ED staff should include other departments such as radiology and laboratory personnel," says Tuck, adding that such meetings should always cover these items:

-a discussion of communicating late lab results and final radiological findings;

-how these communications are to be clearly and consistently documented.

• When a patient's test abnormality is discovered after the patient has been discharged from the ED, the patient should be informed via written, electronic, or telephone contact.

"The contact should be clearly documented, along with any unsuccessful attempts to contact the patient," says Tuck. "Certified mail is one method utilized to provide a verified attempt to relay information."

• Have a dedicated team of registered nurses and support staff to follow up on issues arising after patient discharge from the ED.

"The team's primary purpose is to improve care transitions and communication with patients and primary care providers for patient safety, as well as to avoid legal liability," says Keeler. These are key responsibilities:

-reviewing patient charts and test results;

-phoning patients to give them test results and go over relevant post-discharge issues;

-contacting primary care providers;

-reporting relevant health data to government agencies;

-monitoring patients who leave before being discharged.

-bringing documentation concerns to the attention of EPs.

"In addition to reducing legal liability associated with failure to follow up, this type of program can improve the quality of patient care and improve satisfaction among patients and primary care providers," says Keeler.

When the test result is important in making or ruling out an acute diagnosis, however, by the time the patient or primary care provider is contacted, "it is simply too late," says Barnes. "I cannot stress enough the importance of an EP reviewing a complete set of data before ruling out an acute diagnosis and sending the patient home." ■

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Mock Trials Familiarize EPs with Reality of Med/Mal Litigation

Training can possibly prevent future suit

During residency and medical school, **Dainius A. Drukteinis**, MD, JD, FACEP, attended a number of lectures on medical malpractice. "As I was already a lawyer, it was clear that the concepts could not truly be understood without engaging in the medical malpractice process itself," he says.

Drukteinis is associate medical director of the ED at Tampa (FL) General Hospital and assistant professor of emergency medicine at University of South Florida. During law school, he got involved in extensive mock trial competitions.

"While not a perfect replica, I thought that this was a great opportunity to demonstrate some of these concepts in the way they truly unfold at trial," says Drukteinis. He developed a medical malpractice mock trial competition used to teach residents basic skills for testifying in legal proceedings.

"Being prepared means anticipating problems, documenting appropriately, and communicating your position effectively at the time of litigation," says Drukteinis.

Ten residents in the hospital's emergency medicine program volunteered as witnesses in the mock malpractice trial. Residents testified several times, and were given feedback to prepare them for subsequent rounds of testimony.

The process improved residents' communication skills, and expanded their knowledge of documentation pitfalls.[1]

"For the most part, we knew that the residents would improve their communication skills after they went through the process," says Drukteinis. "They were critiqued, both face-to-face with the 'jury,' and on written score sheets."

A more surprising finding was the residents' lack of improvement in demonstrating empathy for the "patient." "I suspect that because the physicians were so focused on sounding smart and defending themselves, they could not tap into their 'sensitive' side — often the very reason why many physicians went into medicine in the first place," Drukteinis.

Drukteinis believes the participants will feel more confident in defending themselves in a lawsuit, since they've seen the pitfalls of poor communication.

"Perhaps they will even avoid exposure in the first place because of the lessons they have learned regarding documentation and the link between the chart and the perception of medical care by non-physicians," he says.

Many Misconceptions

One of the misconceptions EPs have about medical malpractice litigation is that the physician is a victim without any control over the outcome, says Drukteinis. "Good documentation and effective communication at the time of trial can certainly improve your chances of success, and improve your chances of demonstrating that you did the best that you could," he says.

EPs should know the basic terminology of medical malpractice litigation, such as "negligence," "causation," "subpoena," and "deposition," advises Drukteinis. "We need to learn that medical malpractice exposure should be an expectation for all EPs — not just for some small group of physicians that don't practice appropriately," he says.

There are two types of EPs — "those who have been sued and those who haven't been sued yet," according to **Douglas Segan**, MD, JD, FACEP, a Woodmere, NY-based medical-legal consultant.

Before EPs are named in their first lawsuit, says Segan, "they believe that if they practice good medicine and have good communication skills with the patient and family, the system works and they won't be sued."

When that same EP becomes a defendant and reads the summons and complaint, "they can't believe how they are described," says Segan.

"It's very unsettling when you see a list of accusations in the complaint and your hands are tied," Segan explains. "For the duration of the case, your attorney is your mouthpiece. You have to speak through him or her."

Many EPs have little or no idea how the expert witness process works, he explains. They typically blame patients or families for having unrealistic expectations or ambulance-chasing plaintiff attorneys.

"However, when you go through the process, you realize that the malpractice problem is not with the patients or the plaintiff bar, but with some of our EP colleagues," says Segan.

EPs often don't realize that expert witnesses are paid a great deal of money and that their integrity is sometimes compromised. "All of these cases require another physician to say with a straight face that the care in this case breached the standard of care," says Segan. "And the standard of care that some of our colleagues hold us to is totally unrealistic."

Claims Involve Unusual Presentations

Segan says that while some claims against EPs are clearly malpractice and others have no evidence of malpractice at all, most fall somewhere in the middle. "In the majority of cases, reasonable minds could disagree," he says. "If the claim is reviewed by 10 EPs, five might say the standard of care was met and five might say it wasn't."

Segan says EPs should be more aware of legal risks involving unusual presentations of unusual diseases. He has reviewed several such claims against EPs, such as cases alleging failure to diagnose carotid dissection in a young, healthy patient presenting only with mild weakness in an arm.

"These are difficult diagnoses to make, except with the benefit of hindsight," says Segan. "It won't be difficult when the patient comes back with the tragic outcome of a large CVA [cerebrovascular accident], to hire an expert to say that the standard of care required a CT angiogram."

Segan says EPs can protect themselves legally by being upfront with patients if the diagnosis is unclear. "Humility is our best friend," he says. An EP might say, for example, "Things look fine at this point, but I'm not sure what is going on. Sometimes a serious disease process may be subtle in the beginning, so come back if things change."

It is always better for the EP to express diagnostic uncertainty than to come up with a diagnosis that's not clinically sound, advises Segan. "For example, don't make a diagnosis of constipation or stomach flu in a patient with abdominal pain and a negative workup when the patient has no symptoms of these disorders," says Segan.

In the ED, signs and symptoms might be too early and too subtle to diagnose. Hours later, the patient might have clear signs of a myocardial infarction or CVA. "There is no fatal disease process that doesn't have a beginning, and the onset is frequently subtle and nonspecific," says Segan.

EPs likely feel better when they can label a patient with a diagnosis. "But efforts to squeeze the patient into a diagnostic box that doesn't really fit are a mistake," says Segan. "Once you put a diagnosis out there, the thinking process often ends — both for us and for the patient." ■

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No Documentation of Communication with Other Providers? ED's Defense is Hindered

Charts lack any evidence others were informed

A patient who presented to the emergency department (ED) complaining of nausea and right upper quadrant pain radiating to the epigastric area, difficulty walking and climbing stairs, and difficulty breathing, was presumed to be suffering from cholecystitis and prepared for a cholecystectomy.

In the interim, the emergency physician (EP) had ordered liver function tests (LFTs) and a full cardiac panel. The cardiac panel showed an elevated troponin, and subsequent tests performed the next morning showed normal LFTs, including normal alkaline phosphatase.

"Nevertheless, the care team proceeded with the cholecystectomy. Unfortunately, the patient died during the surgery," says **Angela L. Carr**, JD, a partner in the Providence, RI, office of Barton Gilman.

The plaintiff alleged that the EP and other treating physicians failed to view the elevated troponin level as a red flag that the patient's symptoms had a cardiac etiology.

"The plaintiff placed a significant focus on the fact that the emergency department physician never made any notation in the medical records of having reviewed the results of either cardiac panel," says Carr.

Accordingly, the plaintiff argued that had the physicians reviewed the various test results, they would have ordered a full cardiac evaluation, which would have shown that the patient was not an appropriate candidate for surgery and/or that the patient's symptoms were cardiac in nature. "The defendants were forced to settle," says Carr.

Carr has seen several other claims against EPs with similar fact patterns, involving failure to communicate with other providers. "These cases frequently involve miscommunications that occur as a result of critical values not being reported to all physicians caring for a particular patient," she says.

Failure to Document

Matt Mitcham, senior vice president of claims for MagMutual, an Atlanta-based provider of medical professional liability insurance, has seen several claims against EPs alleging failure to communicate with other EPs, admitting physicians, or other subsequent treating physicians.

These claims typically allege that the EP's failure to communicate with other treating physicians led to an improper diagnosis and a breach of the standard of care, resulting in damage to the patient.

"We see cases all the time where a plaintiff attorney is suing an admitting physician for not coming in and seeing the patient right away," says Mitcham. If the plaintiff attorney alleges the patient's bad outcome was due to lack of definitive treatment, the other treating physician typically points a finger at the EP. "This sets up an immediate conflict," he says. "If the EP isn't already a part of the litigation, he or she soon will be."

A potential defense for the admitting physician is that the information relayed by the EP was not indicative of a more serious issue — even though the EP

remembers relaying this information. Often, there is no documentation to support the EP's version of events.

"Clear documentation of conversations, to include any lab or imaging results entered into the record in real time that were given to the other physician, will provide a good defense to any allegations against the EP," says Mitcham. ■

Sources

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Consider Downside of Employer-paid EP Malpractice Premiums

Hospitals get more control over management of claims

Some emergency physicians (EPs) might jump at an employer's offer to cover the cost of their professional liability coverage. However, there are some potential downsides to this arrangement, warn legal experts.

If the EP's coverage is purchased by the employer, "one of the things you are going to sacrifice is the ability to control litigation," says **Thomas R. McLean**, MD, JD, CEO of American Medical Litigation Support Services in Shawnee, KS.

The EP is no longer the insured, and instead, becomes a third-party beneficiary. "So the EP might not have the ultimate say on what is done with a case where it is alleged the physician engaged in medical malpractice," says McLean.

In a 2013 case, a court ruled that bad faith does not occur when the owner of a group insurance policy approves settlement of a claim within policy limits over the physician's objections.[1]

"The situation is analogous to the EP who is employed. In both cases, the physician is a third-party beneficiary," says McLean. "Third-party beneficiaries just don't get the same rights that the contract maker does."

Most, though not all, malpractice policies state that the insurer won't settle any claim without the EP's consent. However, in some employment agreements, the EP's consent is not required to settle — only the employer's is.

EPs might be able to negotiate the inclusion of a "consent to settle" clause into their malpractice coverage at the time the EP contracts for employment. The employer is unlikely to agree to this, says McLean.

"It is going to depend on how good your reputation in the community is and the employer's risk tolerance," he says. "And to a certain extent, it's going to come down to who the employer has as a lawyer."

An insured EP gets to approve who is hired as the defense attorney. "But if the employer owns the policy, the employer is going to get to pick the defense attorney," McLean says.

Shifting Approach to Malpractice Coverage

With the increasing trend of EPs becoming employed by hospitals or large physician practices, there is an accompanying shift in the approach to malpractice coverage, reports **Johnathan Brutlag**, president of Professional Security Insurance Company, a subsidiary of MagMutual Insurance Company in Atlanta, GA.

"It is increasingly common for employers to provide coverage, either through the purchase of a group insurance policy or through self-insurance vehicles, such as professional liability trusts or captive insurance programs," he says.

In contrast to hospitals, physician aggregators or large practices have generally chosen to provide coverage for their physician members through commercially available insurance products, says Brutlag, often by negotiating specialty "programs" tailored to fit the needs of their specific circumstances.

In the hospital setting, Brutlag is seeing an emerging shift from self-insurance back to private sector coverage. "For several years, we saw hospitals, especially larger, urban systems, bringing coverage for employed physicians into the hospital insurance program, often through some form of self-insurance," says Brutlag. Over the past year or two, many of these health systems have chosen to separate hospital and employed physician coverage for malpractice claims.

"The combination of high funding costs for self-insurance, depressed premiums brought about by increased competition, and a continuing 'soft' commercial insurance market are leading employers back to private insurance," says Brutlag.

Both Pros and Cons to Arrangement

There are some obvious pros and cons to an EP allowing an employer to handle the procurement of medical professional liability coverage, says **Ken Warner**, a claims manager at MagMutual. On the positive side, the individual EPs are relieved of the burden of the insurance purchasing process and, in some cases, the associated costs.

"Additionally, many employers have a designated and experienced insurance buyer or risk manager who understands the complexities of malpractice policies," says Warner. "This potentially allows them to negotiate better terms and/or lower premiums."

In many cases, the employers also purchase higher coverage limits through excess or umbrella placements, providing increased protection to EPs should a malpractice allegation arise. "At the same time, there is an expected loss of control when someone else is responsible for providing an EP's insurance coverage," says Warner.

If the hospital offers to cover an ED physician group as part of their insurance program with the promise of lower premiums, "there is potential cost savings for the physician group. But there are also some pitfalls," warns **Jonathan Katz**, president of Oros Risk Solutions, an Orlando, FL-based insurance and consulting agency specializing in selling medical professional liability insurance.

Seventy percent of hospitals employ a large number of physicians and use their own self-insurance vehicles to insure them, according to the 2013 Aon/ASHRM Hospital and Physician Professional Liability Benchmark report.[2]

"There are clearly benefits to the hospital in doing so. The hospital's interest in doing that is to be able to control the claim," says Katz. "It might be not very advantageous for the physicians, but they won't realize it until they are further down the road."

Katz has seen cases in which EPs covered by a hospital's self-insurance program were unfairly blamed by the hospital during malpractice litigation. "To avoid being a deep pocket, the hospital may blame a claim on the physician," says Katz. "Hospitals may put their interests above the doctor's in certain situations. I've seen it happen many times."

In addition, it might be cheaper for a hospital to settle a malpractice claim than to defend the EP, resulting in serious repercussions for the EP defendant. "If the EP or the group has the ability to purchase their own malpractice insurance, it certainly takes those risks off the table," says Katz. ■

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Hospital and EP Named Jointly? Interests Not Always Aligned

If an emergency physician (EP) and the hospital are both named in a malpractice suit, this can potentially complicate the EP's defense. "The hospital, especially a large hospital that's self-insured, is going to have deep pockets," explains **Thomas R. McLean**, MD, JD, CEO of American Medical Litigation Support Services in Shawnee, KS.

Since the standard malpractice coverage has a $1 million limit, that's the most the plaintiff can obtain from the EP defendant. "But if the plaintiff attorney can show that the EP wasn't properly supervised and the hospital is therefore liable, the sky becomes the limit in terms of what the settlement or jury award could be," says McLean.

The hospital could argue that the EP was the sole causative factor resulting in the patient's bad outcome in order to avoid exposure to much higher policy limits. "If I am the hospital attorney, one of my strategies would be to blame the EP for everything — and that's a million dollars maximum," McLean says. "That's a potentially difficult situation for the EP."

EP May Need Separate Counsel

If the EP is insured under a policy issued to a hos-

pital, or through a hospital's self-insurance plan, "you have to at least wonder whether the insurer is going to give the physician's interests equal consideration to the hospital's interests," says **Robert J. Milligan**, JD, an attorney at Milligan Lawless in Phoenix, AZ.

If settlement on behalf of both the EP and the hospital is a possibility, says Milligan, the EP may need separate counsel to advocate for him or her about whether to settle, and if the claim is going to be settled, what portion of the settlement amount should be allocated to the EP.

"But the issue is not as bad as it may seem," says Milligan. The EP is going to be defended by an attorney with an ethical obligation to look after the EP's interests, regardless of who pays the premium.

If the hospital wants one attorney to defend both the EP and the hospital, the EP might believe his or her interests are in conflict with, or not completely aligned with, the hospital's. At that point, the EP would want to have a discussion with the defense attorney and express concerns about that conflict, advises Milligan.

"Most lawyers don't want to get a bar complaint," he says. If one of two joint clients is concerned about a conflict, attorneys will likely say they are not confident that they can effectively represent both parties. "At that point, the hospital — or its insurer — doesn't have much choice. They have to bring in a separate attorney," says Milligan.

Blaming Hospital is Problematic

If the EP is a hospital employee, Milligan says, "the hospital doesn't benefit from dumping liability on the physician because it bounces right back to the hospital." This isn't the case if the EP is employed by a private group that covers the hospital's emergency department.

"In theory, the hospital may benefit from blaming the physician. And in practice, that may happen sometimes," says Milligan. "But in my experience, when defendants blame each other, the plaintiffs win and the defendants lose."

Milligan has never seen a situation in which an EP successfully defended him- or herself in a malpractice suit by blaming other defendants. "The plaintiff basically gets up and argues, 'The defendants agree on one thing — one or more of them is at fault. So just decide which of them, and give me a verdict," he says.

Milligan recommends that EPs defend their own care without commenting on the care provided by others.

If a patient's bad outcome was linked to a delay in getting test results back, for example, the EP can say, "I ordered the test and I interpreted it when I got it back. It took longer than I would have liked, but that's all I could do." On the other hand, the EP could say, "The hospital's turnaround time on studies is unreasonable, and that's why this happened."

If the EP takes the latter approach, says Milligan, the plaintiff attorney will ask, "How long have you been working at the hospital? If it's such a terrible system, why have you been working there for years?"

If the EP blames the hospital, therefore, the plaintiff attorney can suggest that the EP is partially responsible for the situation. "The EP can aggressively go after the hospital's conduct, which benefits the plaintiff," says Milligan. "Or the EP can defend his or her own conduct, which benefits the EP." ■

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Avoid Unpleasant Surprises with Malpractice Coverage

Emergency physicians (EPs) might be very surprised to learn that if they are sued, the malpractice case could end up being settled without their consent — even if the claim is very defensible — depending on the terms of their malpractice coverage.

This can have serious negative repercussions for the EP. "Obviously, if there is a settlement, that means a National Practitioner Data Bank [NPDB] report, and in some states, a medical board report," says **Robert J. Milligan**, JD, an attorney at Milligan Lawless in Phoenix, AZ.

In some instances, the interests of the insurer can be adverse to those of the EP, says **William Sullivan**, DO, JD, FACEP, an emergency physician at University of Illinois in Chicago and a practicing attorney in Frankfort, IL.

"Physicians are generally unwilling to settle weak malpractice cases against them, since settlement

would result in a report to the [NPDB], and may result in higher insurance rates or difficulty finding future employment," he explains.

Insurers, on the other hand, may wish to settle a weak claim in order to avoid additional expenses of litigation. "If the policy does not require a physician's consent to settle a claim, then the insurer has the ability to settle a nuisance claim against a physician regardless of the claim's merit," notes Sullivan.

Typical policy language permitting such actions will state that the insurer may settle a claim against an insured as it "deems expedient." "Better policy language would state that the insurer may not settle any claim against the insured 'without the insured's advance written consent,'" says Sullivan.

Here are two other questions EPs should get answers to regarding their malpractice coverage:

• Is the policy claims-made or occurrence-based?

Most policies purchased by individual EPs or ED groups are "claims-made," says Milligan. This means that if a claim is made during the policy period and it arises from events that occurred during a policy period, the EP is covered.

"But if the claim arises after the policy period is over, you are out of luck and are not covered," Milligan.

"Claims-made" policies usually have a reporting requirement as well. "So a claim has to be made during the policy period for events that occurred during the policy period and also reported during the policy period in order to bind coverage," says Sullivan.

For this reason, most EPs maintain coverage until they retire or leave the state, says Milligan. However, if EPs become employed and insured by a hospital, the coverage stops when the physician leaves the hospital's employment.

"So EPs have to make sure that the hospital will provide coverage for claims against them involving services that were provided as an employee, even if the claim arises after the EP leaves and the hospital policy is terminated," says Milligan. Most hospital employment agreements Milligan has seen provide occurrence coverage, which means the EP is covered regardless of when the claim is made.

"If it doesn't, it can be a fairly expensive trap for the emergency physician when he or she leaves hospital employment," says Milligan. "The EP has to buy 'tail' or 'nose' insurance, which are separate policies and can be expensive."

• What doesn't the policy cover?

Depending on their specific terms and conditions, malpractice policies may not cover all the types of claims an EP is at risk for, says **Mike Merlo**, JD, managing director of casualty legal and claims at Aon Risk Solutions in Chicago.

"Most professional liability medical malpractice policies provide coverage predominantly for just that — liability arising out of a medical professional service," says Merlo.

The exclusionary language in malpractice policies is important, underscores Sullivan. "While malpractice insurance may cover the physician for mistakes in medical diagnosis and treatment, there are many other acts that malpractice insurance will not cover," says Sullivan.

Intentional acts such as assaulting a patient, grossly negligent acts, fraudulent acts such as changing chart entries without labeling the changes in an attempt to cover up a mistake, and acts that occur while under the influence of drugs or alcohol are excluded from most malpractice coverage. An EP's coverage typically won't cover claims alleging harassment or discrimination.

"An EP might encounter greater risks of claims with those allegations, moreso than a specialized or general physician who has long-term relationships with their patients," says Merlo.

Malpractice policies generally do not cover contractual liability. "This is an important point," says Sullivan. If a physician signs a contract agreeing to supervise mid-level providers or residents, the malpractice policy may not provide coverage if the physician is sued because of the actions of these entities.

"This exclusionary language is even more troublesome when considering that most state licensing acts not only require that mid-level providers work under a supervising physician, but the statutes also require that physicians accept full responsibility for the actions of the mid-level providers," says Sullivan.

Indemnification clauses are another example of a contractual liability that may not be covered under malpractice insurance policies. An EP who agrees to indemnify or "hold harmless" the group or hospital from liability, says Sullivan, may give an insurer the ability to deny coverage in the event of a claim.

"Administrative activities will likely be excluded from malpractice coverage, so liability for actions taken on credentialing committees or medical executive committees may not be covered," says Sullivan. This exclusion may be especially pertinent when committees either refuse to credential a physician or revoke the credentials of a physician, since such actions are more likely to result in litigation.

"Similarly, disciplinary or administrative proceedings against a physician, such as state licensing board investigations, will likely be excluded from malpractice insurance coverage," says Sullivan.

Hospital administrators may be willing to supplement the EP's coverage, or the EP could purchase

insurance for specific areas they aren't covered for.

"EPs might consider telling their employer they have reviewed the policy and are unsure it covers them for areas they might have exposure to, and asking them to pay for a consultant to review the coverage," suggests Merlo.

Regardless, says Merlo, "the EP should make sure they understand what their insurance covers them for. There is no substitute for getting a copy of the policy and reading it." ■

Sources

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Patient's Medication History Was Pivotal Issue in Claim Against EP

Documentation of conversation with patient helped defense

When a patient who presented with a headache was asked about her medications by the emergency department (ED) nurse and again by the emergency physician (EP), she stated only that she was taking albuterol and fluticasone for asthma.

The EP ordered a CT and lumbar puncture, which were both normal, diagnosed the patient with viral meningitis, and gave her a steroid injection. "She also discussed pain meds with the patient," says **Ashley Watkins Umbach,** JD, a senior risk management consultant at ProAssurance Companies in Birmingham, AL.

The patient declined ibuprofen, and the EP administered an opioid narcotic analgesic instead. "The patient signed all of the discharge papers," she says. "She was walking out the door when she passed by the emergency physician, and said the reason she didn't want [ibuprofen] was that she was on [warfarin]," says Umbach. "This was the first anyone had heard of [warfarin]."

The EP asked the patient to stay and let them check her international normalized ratio (INR) levels, but the patient refused. The EP emphasized the importance of following up with her regular provider to ensure that her INR level was within appropriate limits.

"The next day, the physician called the patient to check on her. She reminded the patient to check the INR levels, and documented this in the chart," says Umbach. This documentation ended up being helpful in the EP's defense of a subsequent malpractice suit.

Several days later, the patient presented to another ED with low back pain and an elevated INR of 7.2. "The patient was diagnosed with an epidural hematoma and transferred to a hospital, where an orthopedic surgeon performed a laminectomy," says Umbach. The patient later sued the EP, claiming she had reported taking warfarin from the start of the ED visit.

"The emergency physician had not charted as well as she could have," says Umbach. "She had charted in bits and pieces during her shift, and the timeline was not clear."

It wasn't apparent from the chart that the patient had already been discharged when the EP learned about the warfarin. The EP also didn't chart that she offered to test the INR level while the patient was still physically in the ED, and that the patient refused.

However, the EP did document that she had called the radiologist to recheck the CT scan for evidence of a bleed, and that she called the patient the next day to remind her to check her INR level. "The jury could see that she appreciated the significance of the issue, and was looking out for the patient," says Umbach. "There was a defense verdict."

Standard of Care Varies

If an ED patient gives an inaccurate medication history and is harmed as a result, can the EP be held liable? "Because facts and circumstances differ in every litigated case, it is very difficult to speak generally about what is the standard of care for medication reconciliation in the ED," says **Madelyn Quattrone**, Esq, a senior risk management analyst at ECRI Institute in Plymouth Meeting, PA.

The resources of hospital EDs vary considerably, she explains. An urban or suburban hospital ED that has several hundred beds may have substantially greater resources than a facility with 20 ED beds and that has not yet adopted electronic health records and lacks sufficient pharmacy staff.

"The standard of care with regard to an ED physician and medication reconciliation may be intricately involved with the standard of care for the hospital," says Quattrone.

The question, says Quattrone, is "What should a reasonably prudent emergency physician have done in the same or similar circumstances, with regard to the safe prescribing of medication for the particular ED patient, in the particular circumstances in which the patient presented to the ED?"

"For medication reconciliation, a plaintiff's expert might attempt to hold the hospital to best quality improvement practices for medication reconciliation in the ED," says Quattrone. This may involve use of an electronic health record and involvement of a dedicated pharmacist or pharmacy tech who rounds in the ED.

Document Reason for Overrides

"High-alert" medications, such as anticoagulants, narcotics, and insulin, have a greater risk of causing patient harm if they are used in error, says **Cindy Wallace**, a senior risk management analyst at ECRI Institute.

"The ED practitioner and the ED care team should be educated about the high-alert medications available in the ED, how errors happen with these medications, the steps the hospital is taking to avoid errors, and the staff's role in error-reduction," says Wallace. For example, staff should independently double check the drug name and dose to confirm that it is the right drug and right dose before administering a high-alert medication such as heparin.

"Of course, adherence to recommended practices does not negate the need for good documentation," says Wallace. "The importance of accurate, timely, and complete medical record documentation cannot be overemphasized as a risk management strategy in the ED."

Poor documentation may be viewed by a jury as evidence of the provision of poor care. "Expert witnesses who review documentation for evidence of compliance with the standard of care may find inadequate documentation to support an opinion that the standard of care was met in a particular case," warns Wallace.

As more hospitals adopt electronic health records, they are building in alerts that, for example, prompt a practitioner to double check an unusually high or low dose ordered for a particular drug. "Here, documentation is essential if the practitioner chooses to override the alert," says Wallace.

An EP could be asked to provide the rationale for the override in a court case involving the care provided. "An electronic system that requires users to document reasons for clinical overrides may generate documentary evidence if the decision to override is later questioned in a malpractice case or in peer-review proceedings," says Wallace. ■

Sources

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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. ■

CNE/CME INSTRUCTIONS

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

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

2. Scan the QR code below, or log on to **www.cmecity.com** to take a post-test. *First-time users will have to register on the site using the 8-digit subscriber number printed on their mailing label, invoice, or renewal notice.*

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

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

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

CNE/CME QUESTIONS

1. Which is true regarding a malpractice mock trial competition for residents, according to a 2014 study?
   A. The process improved residents' knowledge of documentation pitfalls.
   B. The residents reported less understanding of documentation pitfalls.
   C. The residents demonstrated significantly more empathy for patients.
   D. Residents' ability to communicate effectively decreased.

2. Which is recommended regarding claims against emergency physicians (EPs) involving poor communication, according to **Matt Mitcham**?
   A. EPs should avoid documenting telephone conversations with other providers involved in the patient's care.
   B. EPs should clearly and timely document conversations with other treating physicians.
   C. The best defense for EPs is to place blame on other treating physicians.
   D. EPs have the best chance of being dismissed from the claim if the discovery process reveals conflicts over what was said and done.

3. Which is true regarding malpractice coverage when the emergency physician (EP) is a hospital employee?
   A. Some policies state that the hospital can settle claims without the physician's consent.
   B. All employment agreements require the EP's consent to settle malpractice claims against the EP.
   C. If the EP's interests are in conflict with the hospital's and the hospital wants one attorney to defend both the EP and the hospital, the EP has no recourse.
   D. If the EP and hospital are jointly named, the hospital is unable to argue that the EP was the sole causative factor resulting in the patient's bad outcome.

4. Which is true regarding emergency physicians' malpractice coverage?
   A. Claims-made policies cover claims arising after the policy period is over.
   B. With a claims-made policy, EPs are covered only if a claim is made during the policy period and it arises from events that occurred during a policy period.
   C. If the EP becomes employed and insured by a hospital, claims-made coverage continues even after the EP leaves the hospital's employment.
   D. Occurrence coverage doesn't cover claims against the EP if the claim arises after the EP leaves and the hospital policy is terminated.