ED LEGAL LETTER™

THE ESSENTIAL RESOURCE FOR EMERGENCY MEDICINE MALPRACTICE PREVENTION AND RISK MANAGEMENT

FEBRUARY 2015 Vol. 26, No. 2; p. 13-24

INSIDE

Georgia Courts Continue to Define the State's Emergency Care Reform Law

Georgia's tort reform law protecting hospitals, emergency physicians, and on-call physicians providing 'emergency medical care' remains at the forefront of medical malpractice litigation.

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

Recently the court decisions have favored providers, particularly in cases in which the emergency physician failed to diagnose a patient's emergency medical condition.

The Case of *Nguyen v. Southwestern Emergency Physicians, P.C.*[1]

The facts of the case were simple and not in dispute. While in the care of a babysitter, a 6-month-old child fell off the bed and hit her head on a suitcase. Alarmed by an "apple-sized, red-purple lump" on the right side of the baby's head, her mother took the child to the Putney Memorial Hospital emergency department. A physician's assistant examined the child immediately and diagnosed a "scalp contusion," calling it a "minor injury," and sent the child home exactly eight minutes later — without involving the attending emergency physician or ordering an imaging study. Three days later, the child returned to the ED with respiratory depression, and a CT scan revealed a very large subdural hematoma causing increased intracranial pressure. The end result was severe and permanent neurological injury.[1]

Financial Disclosure: The following individuals disclose that they have no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study: **Arthur R. Derse**, MD, JD, FACEP (Physician Editor), Director and Professor, Center for Bioethics and Medical Humanities, Institute for Health and Society, Medical College of Wisconsin, Milwaukee, WI; **Robert Bitterman**, MD, (Contributing Editor); **Stacey Kusterbeck** (Contributing Editor); **Shelly Morrow Mark** (Executive Editor); and Leslie Hamlin (Managing Editor). **Kay Ball** RN, PhD, CNOR, FAAN, Consultant/ Educator, K&D Medical Inc., Lewis Center, OH (Nurse Planner) is a speaker for AORN and a stockholder for STERIS, Inc.

AHC Media

ED LEGAL LETTER

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.
customerservice@ahcmedia.com.
www.ahcmedia.com

EDITORIAL E-MAIL ADDRESS:
leslie.hamlin@ahcmedia.com.

SUBSCRIPTION PRICES:
Print: 1 year with free *AMA PRA Category 1 Credits™*: $519.
Add $19.99 for shipping & handling.
Online only: 1 year (Single user) with free *AMA PRA Category 1 Credits™*: $469

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.

ACCREDITATION: AHC Media, LLC is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

AHC Media, LLC designates this enduring material for a maximum of 18 *AMA PRA Category 1 Credits™*. Physicians should claim only credit commensurate with the extent of their participation in the activity.
Approved by the American College of Emergency Physicians for a maximum of 18.00 hour(s) of ACEP Category I credit.

AHC Media, LLC is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

This activity has been approved for 15 nursing contact hours using a 60-minute contact hour.
Provider approved by the California Board of Registered Nursing, Provider #14749, for 15 Contact Hours.
This activity is intended for emergency physicians and nurses. It is in effect for 36 months from the date of the publication.

Opinions expressed are not necessarily those of this publication, the executive editor, or the editorial board. Mention of products or services does not constitute endorsement. Clinical, legal, tax, and other comments are offered for general guidance only; professional counsel should be sought in specific situations.

EDITORIAL/CE DIRECTOR: Lee Landenberger
EXECUTIVE EDITOR: Shelly Morrow Mark
MANAGING EDITOR: Leslie Hamlin
EDITOR-IN-CHIEF: Arthur R. Derse, MD, JD, FACEP
CONTRIBUTING EDITOR: Stacey Kusterbeck.

The parents sued the hospital, the physician assistant, the supervising emergency physician, and the physician's group (failure to have policies and procedures in place to adequately supervise the physician assistant) for negligence. They asserted that none of the ED providers who saw the child believed that her signs and symptoms presented a medical emergency, and, therefore, she did not receive "emergency medical care" as defined by Georgia law.[2] Accordingly, the plaintiffs argued that the defendants could be held liable for ordinary negligence — that it was not necessary for them to prove the defendants were grossly negligent.[1]

Georgia's Statute

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."[3]

In other words, if the care provided by the physician's assistant in the ED constituted "emergency medical care," the plaintiffs would have to prove at trial by clear and convincing evidence that the physician's assistant was grossly negligent in his diagnosis and treatment of their child. If the care did not constitute "emergency medical care" as defined by Georgia law, then the plaintiffs would have to prove only that the physician's assistant was negligent by a preponderance of the evidence — which is much easier to satisfy to the jury.

Georgia 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 nonemergency patient or care that is unrelated to the original medical emergency."[4]

Naturally, the defendants argued that the physician's assistant and the ED did indeed provide "emergency medical care" to the child, and, thus, should be allowed to claim the protections of the "gross negligence" standard set out in the state's tort reform law.[1]

The Court's Analysis

The court noted that there are three conditions that must be present in order for the defendants to claim the benefits of the gross negligence standard. First, the lawsuit must involve a "health care liability claim"; second, the claim must arise out of the provision of "emergency medical care"; and third, the care must have been provided to the patient "in a hospital emergency department or obstetrical unit or in a surgical suite immediately following

the evaluation or treatment of a patient in a hospital emergency department."[1,5]

It was undisputed that the plaintiffs' complaint constituted a "health care liability claim"[6] or that the infant received treatment in "a hospital emergency department."[3]

The question then was whether the child was provided "emergency medical care" even though the examining physician's assistant didn't believe an emergency condition existed and the patient wasn't ever treated for an emergency condition.

In a previous case, *Howland v. Wadsworth*, the Georgia Appeals Court allowed an ED health care provider to claim the benefit of the statute's "gross negligence" standard when he mistakenly concluded that a patient was "capable of receiving medical treatment as a nonemergency patient."[7] ("Emergency medical care" does not include medical care or treatment that occurs after the patient is stabilized and is "capable of receiving medical treatment as a nonemergency patient.")[8] Thus, a health care provider who does not realize the seriousness of the patient's condition can still be protected under the statute. The court ruled that the definition of "emergency medical care" depends on the actual medical condition of the individual patient, not the diagnosis made in the ED or the manner in which the condition was treated.[1,7,9]

Therefore, the court concluded in this case that the jury must decide whether when the child presented at the ED with a large red-purple lump on her head she was suffering from an actual emergency — that is, whether she presented a "medical or traumatic condition manifesting itself by acute symptoms of sufficient severity" such that "the absence of immediate medical attention could reasonably be expected" to place her health "in serious jeopardy."[1]

This ruling by the court means that "failure-to-diagnose claims" against emergency physicians may still be covered by the gross negligence statute, provided that the medical condition that the physician failed to diagnose was a true "emergency medical condition" (EMC) as defined by Georgia law, which happens to be the exact same definition found in the Emergency Medical Treatment and Labor Act (EMTALA).[10]

Interestingly under federal EMTALA law, if the emergency physician subjectively believes the patient does not have an EMC, even if that determination is incorrect and negligent, there can no litigation for failure to stabilize the EMC. Under EMTALA, the emergency physician must have actual knowledge that the emergency exists (i.e., make the diagnosis of the emergency medical condition). Thus, in this case, since the physician's assistant determined the blow to the head was a "minor injury," the plaintiffs could not sue the hospital under EMTALA for "failure to stabilize" the subdural hematoma. Nevertheless, under Georgia law, if the blow to the head caused an actual EMC as defined by Georgia and EMTALA, and a subdural hematoma should meet that definition, then the physician's assistant would be judged under the gross negligence standard rather than the ordinary negligence standard.

Unfortunately for the physician assistant and his codefendants in the case, the court wouldn't decide as a matter of law that the child presented with an actual emergency medical condition. It concluded, as it has repeatedly in other cases, that "the issue of whether a claim for negligence involves the provision of emergency medical care is a question of fact for the jury."[11] Thus, the jury would have to decide whether the physician's assistant's care would be judged under the gross negligence standard, and if so, whether the plaintiff proved he was grossly negligent by clear and convincing evidence.

"Bona Fide Emergency Services"

The plaintiffs tendered one more argument to the court, as an earlier *ED Legal Letter* expected would eventually occur,[12] that the services provided in the ED were not "bona fide emergency services" and, therefore, did not constitute "emergency medical care," which would void the protection of the gross negligence statute.

The legislature did not define the meaning of "bona fide" for the purposes of the tort reform law, so the court looked to an earlier Georgia Supreme Court case, *Abdel-Samed v. Dailey*, for its interpretation.[13] According to the high court, "bona fide" is a phrase of general usage and should be given its ordinary meaning, which includes actions taken "in good faith" or which are "genuine" and "true."[13] The American Heritage Dictionary defines "bona fide" as "made or carried out in good faith," "authentic," or "genuine." Webster's Dictionary similarly defines "bona fide" as "real or genuine," "made or done in an honest and

sincere way." The court noted that strict dictionary definitions thus suggested two possible meanings for the term "bona fide": either "in good faith" or "genuine" and "true."

The plaintiffs in the *Nguyen* case wanted to utilize the "good faith" definition so they could argue that the services provided by the physician's assistant in a total of eight minutes, with no diagnostic testing and without the input from the supervising emergency physician, were not provided "in good faith," and, thus, were not "bona fide" emergency services due the protection of the statute.[1]

Nonetheless, the Court found "bona fide" emergency services to mean genuine or actual emergency services, and that emergency room personnel provide such services to ED patients when they examine and diagnose them — as when the physician's assistant examined and diagnosed the child in the emergency room after her fall, even if his diagnosis of a simple "contusion" was ultimately proven incorrect.[1]

The court ruled that if the legislature wanted to interject a "good faith" requirement into the statute, it would have done so explicitly in the same way it has limited a health care provider's tort liability in many similar situations, such as requiring a physician to act in good faith when reporting a case of child abuse or when rendering emergency medical care at the scene of an accident as a Good Samaritan.[13]

In conclusion, the court ruled that the physician's assistant did provide "bona fide" emergency services, and it was up to the jury to determine if the child had an actual emergency medical condition at the time the services were provided. If the jury determined an emergency medical condition was present, then it was to decide whether the plaintiffs proved by clear and convincing evidence that the physician's assistant was grossly negligent in his care of the child.

Comment

Two rulings favorable to emergency department health care providers emerged from these court decisions. First, the definition of "bona fide" emergency services equates to the usual diagnostic and therapeutic services provided in the ED — history, physical exam, plus/minus use of diagnostic testing, medical decision-making, treatment, and disposition. There is no additional or hidden requirement encompassed in its meaning.

Second, even in failure-to-diagnose cases, the emergency physician or examining health care provider will be afforded the protection of the gross negligence statute, provided the missed diagnosis was an actual emergency medical condition as defined by EMTALA and Georgia laws.

Medicine and litigation being what they are, it is unlikely that failure-to-diagnose cases will lead to significant patient harm worth substantial money damages unless the diagnosis missed was a true emergency medical condition.

Dr. Bitterman's Additional Comments

A majority of these precedent-setting cases in Georgia stem from ED encounters in which the patient was seen by a physician's assistant alone, without any or significant involvement of the supervising emergency physician. To repeat the admonition of the July 2014 *ED Legal Letter* article on Georgia's tort reform law, hospitals and emergency physician groups should not let patients with potential life- or limb-threatening presentations be seen by a mid-level provider alone. The emergency physician should *always* personally examine these patients and become intensely involved in their care. ■

REFERENCES

1. *Southwestern Emergency Physicians, P.C. v. Nguyen*, A14A0942 (Georgia Court of Appeals, November 21, 2014.)
2. OCGA § 51-1-29.5 (a).
3. OCGA § 51-1-29.5 (c).
4. OCGA § 51-1-29.5 (a) (5). Emphasis supplied by the court.
5. *Nisbet v. Davis*, 760 S.E.2d 179 (Ga. App. 2014),
6. See OCGA § 51-1-29.5 (a) (9) defining "health care liability claim" to include a cause of action against a physician or health care provider for treatment or lack of treatment.
7. *Howland v. Wadsworth*, 749 S.E.2d 762 (Ga. App. 2013).
8. OCGA § 51-1-29.5 (a) (5).
9. See also *Bonds v. Nesbitt*, 747 S.E.2d 40 (Ga. App. 2013).
10. 42 USC 1995dd.
11. *Howland v. Wadsworth*, 749 SE2d 762 (Ga. App. 2013), citing *Bonds v. Nesbitt*, 747 S.E.2d 40 (Ga. App. 2013).
12. Bitterman RA. Is Georgia's Emergency Care Tort Reform Coming Apart? Courts Carve Out Exceptions to Georgia's Emergency Care Statute. *ED Legal Letter* 2014;25(7):73-78.
13. *Abdel-Samed v. Dailey*, 755 S.E.2d 805 (Ga. 2014).

Simple Communication Practices Can Prevent Some ED Claims: Angry Patients Sometimes Just Want Answers

Rude, dismissive treatment is underlying cause of many malpractice suits

A 49-year-old patient presented to an emergency department (ED) with complaints of eye pain, blurred vision, and unsteady gait. "A limited physical exam was undertaken, during which time the patient found the attending rude and dismissive," says **Sue Larsen**, co-founder and chief operating officer of Astute Doctor Education in Laguna Niguel, CA.

When the patient expressed his concern that it might be something serious, the attending interrupted and told him not to overreact. The patient was discharged with a diagnosis of corneal abrasion, macular elevation, and hypertension retinopathy, but returned the next day with continued blurred vision, headache, and altered mental state. A CT scan revealed posterior and anterior artery stroke, leaving the patient permanently incapacitated.

"The patient and his family sued, sparked by the dismissive way in which he had been treated," says Larsen.

In another case, a busy emergency physician (EP) arrived at a patient's room for the initial exam, eager to move on to the next patient. "The patient wanted to 'tell his story.' However, the doctor was out of there quickly, after ordering a series of tests," recalls **Kathy Dolan**, RN, MSHA, CEN, CPHRM, senior risk resource advisor at ProAssurance Casualty, a Madison, WI-based provider of professional liability insurance.

When the patient was finally reassessed, it was determined that additional testing was indicated. This resulted in a lengthy delay in diagnosis, treatment, and discharge, angering the patient and family. "The medical director and a nurse, with outstanding conversational skills, spent a great deal of time with the patient," says Dolan. Together, they explained the chaotic nature of emergencies and apologized on behalf of the EP. A meal was delivered to the patient while she waited for the test results, and her family was provided lunch cards.

"The end result was an admission and a later transfer for her condition," says Dolan. "It was an extensive effort to correct that initial meeting with the physician."

Most litigation against EPs stems from poor communication, not lack of clinical competency, says Larsen. This is not readily apparent, however, as published cases typically focus on the precipitating clinical factors without giving details of the communication deficiencies that were involved in the patient's decision to sue.

"When plaintiffs are asked what caused them to sue in the first place, generally they say it is because of how the doctor communicated with them," Larsen says. "Rarely, however, do these specific drivers get reported with closed cases when they are written up." Here are some approaches that can mitigate risk for EPs:

• Use scripting to explain the process of the ED visit.

"ED nurses can explain that diagnosing illness in the ED will take time, and inform patients of average wait times for various tests and specialty consultation," says Dolan. She gives this example of scripting to use at triage: "My name is Kathy and I am a nurse. I want to let you know that life-threatening situations and serious conditions will be cared for first, ahead of less serious illnesses and injury. We will be checking on you frequently, but if you feel something has changed, I will be happy to reassess your condition."

• Post white boards in patient rooms to let them know what was ordered, what has been returned and what still is being processed.

"This keeps the patient informed," says Dolan. "If patients are placed in a room with no communication for hours on end, it can lead to problems."

• Encourage nurses to involve others if they detect unresolved issues at discharge.

"A perceptive staff member should stop the process and get the physician, nurse, and patient dialoguing on what the issue is," says Dolan.

• If a patient leaves the ED dissatisfied or has an unexpected bad outcome, make a follow-up phone call to address unresolved concerns.

"One of the main reasons that patients or family seek out legal counsel after an unexpected bad outcome is to get answers," says **John Tafuri**, MD, FAAEM, regional director of TeamHealth Cleveland (OH) Clinic and chief of staff at Fairview Hospital in Cleveland.

If there is an unexpected bad outcome, the ED director could call the patient or family and ask, "Do you have any questions? Is there anything that you don't understand?"

"Otherwise, they may go to an attorney to get those answers. Once an attorney is involved, there is likely to be a lawsuit," says Tafuri. If the patient's questions are answered upfront, on the other hand, they often won't feel a pressing need to call a lawyer.

"If you are very specific, and give honest answers, most patients appreciate it," says Tafuri. "Most patients are willing to give the physician the benefit of the doubt if he or she is honest and forthright."

The EP who originally saw the patient isn't necessarily the best person to make this call, adds Tafuri. Ideally, the call should be made by an ED director or a neutral person who would not otherwise be involved in the case.

There is always the chance that the individual who makes the call will be deposed about what was said. "But in my experience, a frank discussion at the time of the incident or a follow-up call to the patient or family mitigates risk," says Tafuri.

In one such case, a 35-year-old healthy patient was brought in with a stable drug overdose. The EP intubated the patient and the nurse was instructed to administer charcoal via an Ewald tube.

"Unfortunately, the nurse placed a nasogastric tube into the lung, despite the intubation, and administered the charcoal," says Tafuri. "The patient died within 10 minutes."

Despite the objections of the nursing supervisor, the EP informed the family of exactly what happened and answered all of their questions. No lawsuit was ever filed.

"If the family had not been informed contemporaneously and later discovered that the patient had died of a misplaced tube by the nurse, a lawsuit would have been a virtual certainty," says Tafuri. ■

SOURCES

- **Kathy Dolan**, RN, MSHA, CEN, CPHRM, Senior Risk Resource Advisor, ProAssurance Casualty, Madison, WI. Phone: (608) 824-8308. E-mail: kdolan@proassurance.com.
- **Sue Larsen**, Astute Doctor Education, Laguna Niguel, CA. Phone: (646) 783-1000. E-mail: SueLarsen@AstuteDoctor.com.
- **John Tafuri**, MD, FAAEM, Regional Director, TeamHealth Cleveland (OH) Clinic. Phone: (216) 476-7312. E-mail: jotafu@ccf.org.

New Ruling on NPDB Reporting Requirements Affects ED Programs for Early Resolution of Potential Claims

Written demand for payment is determining factor

Early offers of compensation to an emergency department (ED) patient may require reporting to the National Practitioner Data Base (NPDB), according to a May 22, 2014 ruling from the Department of Health and Human Services (HHS).

All medical malpractice claims that include a written demand for payment must be reported to the NPDB, even if the cases are resolved under state programs designed to settle the matters outside of court.

The ruling specifically addresses alternate dispute resolution laws in Oregon and Massachusetts, which use Disclosure, Apology, and Offer programs to facilitate settlements and avoid protracted litigation. The ruling states that Oregon's law was "explicitly designed to avoid medical malpractice reporting to the NPDB for any claims that are part of the new process that do not proceed to litigation."

"The HHS ruling certainly eliminates one potentially attractive feature of these alternative dispute resolution models by preserving the

requirement of NPDB reporting," says **William M. McDonnell**, MD, JD, clinical service chief of emergency medicine and medical director of the emergency department (ED) at Children's Hospital & Medical Center in Omaha, NE.

The HHS ruling specifically observed that Massachusetts and Oregon were the only states with existing legislation creating such alternative dispute resolution systems, but also noted that other states were considering similar models for future implementation. "The HHS memo seems pretty clearly to extend its decision to all existing and future state malpractice alternative dispute resolution models," says McDonnell.

The ruling carefully distinguishes between "written claims," which are reportable to NPDB, and claims for payment in a "non-written form," such as telephone calls or conversations. "The HHS noted that when a compensation offer is initiated by the provider and no written demand for payment is made, no NPDB report is necessary," says McDonnell. Orally communicated demands for payment do not generate a requirement for NPDB reporting.

"Therefore, alternate dispute resolution programs that very proactively address the spoken concerns of patients, and quickly generate fair and reasonable settlements, might avoid NPDB reporting," says McDonnell.

The ruling simply means that the requirement for an NPDB report doesn't get waived when the physician agrees to compensation under an alternate dispute resolution program, if the resolution arose from a written claim by the patient, he explains.

"The ruling doesn't affect the arguably much more important potential benefits of early resolution programs," says McDonnell. These include quicker and more cost-effective resolution of disputes, and reduced litigation-related stress on all parties.

"Even if NPDB reporting is necessary, emergency physicians may find it to be far more cost-effective to proactively use an alternate dispute resolution process when appropriate under the facts and circumstances," concludes McDonnell.

In some cases, ED patients threatening legal action simply need an outlet for their anger and frustration. A lawsuit may be less likely if this is provided before a patient leaves the ED, according to McDonnell.

"When your program has a professional trained to listen to complaints and take actions when appropriate, fewer patients may feel that litigation is their best, or only, option," he says.

Early resolution programs in EDs work best when the disclosure can be made promptly; when supportive or remedial care is provided to the patient; and when emotions such as anger, fear, frustration, and suspicion are addressed before a legal claim is filed, says McDonnell.

"There is some evidence that such disclosure programs can reduce the likelihood and costs of legal claims," says McDonnell.[1,2] "There is also the chance that that disclosure can actually stimulate some claims."

Evolving Role of Risk Management

Some EDs are involving insurance carriers and risk managers earlier in the process in an attempt to reduce the likelihood of protracted litigation.

"The role of risk management has evolved beyond defense of formal claims made into active, early involvement in potential quality and safety issues," says **Terrence W. Brown**, MD, JD, FACEP, chairman of the ED at Banner Estrella Medical Center and counsel to the Emergency Physician Insurance Program, both in Phoenix, AZ. At times, informal mediation is used to reach a quick settlement.

"Many insurance policies and hospital bylaws require reporting of certain adverse events, near-misses, and claims," adds Brown. These reporting requirements sometimes include a list of scenarios in which lawsuits are often contemplated with higher frequency regardless of the quality of the care provided, such as unplanned returns, deaths, and discharges against medical advice.

"For patients, or families, who are simply confused, hurt, or surprised by an adverse outcome, an honest, measured dialogue — not a rambling confession — may be all that is necessary to halt any legal action," says Brown.

No Downside of Early Involvement

EPs commonly respond to patient complaints or threats of "you'll hear from my attorney" by responding in kind with defensive replies. "These escalate the possibility of litigation," warns Brown.

In situations in which legal action is inevitable, such statements "will be subject to dissection

by a plaintiff's attorney," says Brown. "All of this is discoverable and frequently used to show inconsistency or conflict, and otherwise discredit the EP's actions."

EPs who choose to communicate to patients, family, or others without the advice of counsel risk complicating the defense of an eventual claim. "Doctors have destroyed defensible cases by discussing the details of an event, and potential litigation, with the nurses or consultants involved in the patient's care," warns Brown.

By consulting with risk managers, insurance carriers, or defense attorneys, EPs can determine how to best respond to emotional, complicated, and often frustrating scenarios. "Early consultation with counsel has no downside," says Brown. "It carries the protection of attorney-client privilege, and can benefit the EP." ■

REFERENCES

1. Boothman R, 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(3):13-27.
2. Kachalia A, Kaufman SR, Boothman R, et al. Liability claims and costs before and after implementation of a medical error disclosure program. *Ann Intern Med*. 2010;153(4):213-221.

SOURCES

- **Terrence W. Brown**, MD, JD, FACEP, Chairman, Department of Emergency Medicine, Banner Estrella Medical Center, Phoenix, AZ. Phone: 602-839-6968. Fax: 602-839-4144. E-mail: twbrown86@hotmail.com.
- **William M. McDonnell**, MD, JD, Clinical Service Chief, Pediatric Emergency Medicine/Medical Director, Emergency Department, Children's Hospital & Medical Center, Omaha, NE. Phone: (402) 955-5140. E-mail: wmcdonnell@ChildrensOmaha.org.

Defensive Medicine Can Complicate Emergency Physician's Defense

Ordering tests that aren't indicated can backfire legally

Many emergency physicians (EPs) believe that ordering a diagnostic test is always legally protective, but this is a dangerous fallacy, according to **Robert Suter**, DO, MHA, professor of emergency medicine at UT Southwestern Medical Center in Dallas, TX.

"That is absolutely not true. You really have not done yourself any favors whatsoever by ordering a test that is not indicated with the rationalization that it is good risk management," he says.

Ordering a test indicates that the EP believes there is a reasonable probability that a particular condition exists. "You can't say that you didn't suspect a diagnosis that you ordered a test for," says Suter. "A nasty plaintiff attorney could say, 'Doctor, did you order that test because you are unethical or because you are stupid?'"

Since most tests do not have 100% sensitivity, the EP might someday be in the position of explaining to a jury why the patient appeared to be discharged solely on the basis of the negative test result. It could appear to a jury that the EP felt that simply ordering a relatively low-sensitivity test was sufficient to exclude the diagnosis.

"That is a huge trap that even good emergency physicians fall into, and they don't seem to realize it," says Suter. For EPs wavering over whether or not to order a diagnostic test, Suter says good documentation explaining why it wasn't done can strengthen the EP's defense:

• That the EP considered more serious causes of the complaint, but based on the history and physical exam, there was insufficient reason to justify testing.

For instance, the EP might document, "Chest pain and other symptoms relayed by the patient are not consistent with myocardial infarction (MI). There are no symptoms of sufficient duration to believe that the patient has an MI or that would indicate diagnostic use of cardiac enzymes in the ED."

• That the EP gave the patient appropriate warnings on reasons to return to the ED.

The EP might chart, "Patient warned to come back for further

testing if they develop persistent chest pain or other symptoms."

In the case of troponins, patients can get a falsely reassuring message if they are told simply that blood tests show they didn't have a heart attack. "I've seen some really tragic cases where a patient gets discharged from the ED, or is even admitted to a chest pain unit for serial troponin examinations and discharged when they are negative, when their chest pain was clearly of anginal duration," says Suter.

In some cases, the chest pain recurred but the patient didn't return to the ED because he or she relied on the negative test results, leading to a massive MI.

"That is a real tragedy for the patient, and is a setup for a multimillion dollar lawsuit," says Suter.

A much better outcome for both the patient and the EP could have been obtained, he adds, by communicating the options and clinical uncertainty at the time of the first visit, then telling the patient to return by emergency medical services if the pain comes back and persists.

Liability Fears May Contribute to Crowding

A 2013 commentary hypothesized that defensive practices may contribute to ED crowding.[1] "We seem to spend a lot of time on low-acuity patients where we worry about missing things. In the back of my mind, I always thought this was because we are worried about liability risks," says **Darren P. Mareiniss**, MD, JD, the paper's author. Mareiniss is an emergency medicine faculty physician in the Department of Emergency Medicine at the University of Maryland School of Medicine in Baltimore, MD.

EPs' liability fears have been linked to increased propensity to extend workups, request low-acuity admission, and order radiologic studies,[2,3] and ED crowding has been shown to negatively affect patient care.[4] In light of this, EPs should consider how their workup might be inappropriate, suggests Mareiniss. "By contributing to crowding, defensive practices could detract from care in the ED," he says.

Tests May Give False Assurance

Labs or imaging tests with insufficient diagnostic sensitivity can give both EPs and patients false reassurance. For example, "cardiac troponins are 100% sensitive for MI at 12 hours, and that is a wonderful fact," says Suter. However, infarction takes 20 minutes of complete myocardial ischemia; lesser episodes do not cause MI, and these periods of ischemia cannot reliably be detected by the troponin test.

Some EPs order troponins on patients who have less than 20 minutes of symptoms, and so fall into the ischemia rather than the infarction spectrum of acute coronary syndrome. "Troponins are only 55% sensitive for ischemia," notes Suter. "That is okay as long as the patient is going to be admitted."

However, if a patient with symptoms lasting five to 10 minutes per episode is sent home from the ED after a negative troponin level and then subsequently has an MI, "you have really put yourself in a much worse position by ordering the troponin, than if you hadn't," says Suter.

If the patient sues for failure to diagnose an MI, the plaintiff attorney will ask the EP why the patient was sent home when cardiac disease was suspected. If the EP responds that he or she didn't think the patient had cardiac disease, the lawyer will ask why the troponin was ordered.

"At that point, you only have two answers, neither of which is good," says Suter. The EP can respond that he or she didn't realize the test wasn't 100% accurate. "The plaintiff attorney can then ask, 'Did you miss class when they talked about the physiology of MI and cardiac enzymes, doctor?' It could be very ugly," says Suter.

Or the EP can respond, "I decided to make a life or death decision for my patient, the plaintiff, based on a test that I knew was only a little bit more accurate than flipping a coin," says Suter.

For a patient with chest pain, whom the EP plans to discharge because the symptoms do not appear to be cardiac and are of insufficient duration to be an MI, Suter says that in most cases, the EP is better off not ordering cardiac enzymes. Instead, he says, "justify your disposition based on clinical and historical factors arguing against cardiac disease considerations."

Similarly, instead of ordering a CT scan for a patient with abdominal pain that appears to be benign, for instance, a better approach might be to discharge

the patient with a careful clinical examination and informing the patient that "there is always a very small chance it is something more serious that is too early to diagnose," says Suter, with clear instructions to return to the ED if the pain persists or worsens.

"That is a far better plan than to do a CT scan and tell them that they don't have a serious condition, when you should know that CT is not 100% sensitive for many common abdominal conditions, and so there is still a chance of a serious disease being present," says Suter.

CT scans of the brain are often ordered for patients presenting with weakness, dizziness, or headache without EPs carefully considering the appropriateness and reliability of the test, says **Jonathan Edlow**, MD, vice-chair and director of quality in the Department of Emergency Medicine at Beth Israel Deaconess Medical Center in Boston.

"EPs often do it because it's fast and widely available, and the patients are glad they've had a test," he says. "But if a CT is ordered without thinking through the sensitivity of the test, it can get them into trouble."

For a patient with an acute-onset thunderclap headache, CT is not reliable for acute subarachnoid hemorrhage (SAH) if the patient presents more than six hours after onset, notes Edlow. "CT is a pretty lousy test for an acute ischemic stroke, and it's a horrible test for acute cerebellar or brainstem stroke," he adds.

Edlow has reviewed several claims against EPs in which the chart suggested that the EP believed that stroke or SAH was excluded because of a negative CT scan. "The plaintiff's side will pick it apart and say there was a bad outcome because the emergency physician didn't do the right test," he says.

If the EP doesn't think that the patient's story suggests a cerebrovascular cause, says Edlow, it's better to document the reasons than to do a scan that is not helpful to rule out the diagnosis. "Of course, one has to have good reasons — elements of the history and physical examination — that inform one's actions," he says. ■

REFERENCES

1. Mareiniss DP. Could fear of malpractice contribute to ED crowding? *Amer Journ Emerg Med* 2013;31(11):1612-1613.
2. Katz DA, Williams GC, Brown RL, et al. Emergency physicians' fear of malpractice in evaluating patients with possible acute cardiac ischemia. *Ann Emerg Med* 2005; 46:525–533.
3. Wong AC, Kowalenko T, Roahen-Harrison, S, et al. A survey of emergency physicians' fear of malpractice and its association with the decision to order computer tomography scans for children with minor head trauma. *Pediatr Emerg Care* 2011;27:182-185.
4. Berstein, SL, Aronsky, D, Duseja, R, et al. The effects of emergency department crowding on clinically oriented outcomes. *Acad Emerg Med* 2009;16:1-10.

SOURCES

- **Jonathan Edlow**, MD, Department of Emergency Medicine, Beth Israel Deaconess Medical Center, Boston, MA. Phone: (617) 754-2329. E-mail: jedlow@bidmc.harvard.edu.
- **Darren P. Mareiniss**, MD, JD, Department of Emergency Medicine, University of Maryland School of Medicine, Baltimore, MD. E-mail: dmareiniss@umem.org.
- **Robert Suter**, DO, MHA, Department of Emergency Medicine, UT Southwestern Medical Center, Dallas, TX. Phone: (214) 648-4838. E-mail: robert.suter@utsouthwestern.edu.

Malpractice Reform Didn't Change EPs' Practices, Says Study

Three states (Texas in 2003; and Georgia and South Carolina in 2005) enacted legislation that changed the malpractice standard for emergency care to gross negligence. However, this had little effect on emergency physicians' (EPs) intensity of practice, according to a recent study.[1]

"For the emergency medicine community, it's been fairly eye-opening," says **Daniel Waxman**, MD, a scientist at the RAND Corporation and a member of the emergency medicine faculty at University of California, Los Angeles. "Once people get past the surprise, I think they have generally accepted the finding."

Researchers analyzed ED visits for more than four million Medicare fee-for-service beneficiaries, both in the three reform states and in neighboring states, from 1997 through 2011. They found no reduction in the rates of CT or MRI utilization or hospital admission in any of the three reform states.

"What we found, essentially, is that there was no measurable effect," says Waxman.

The motivation for the study was the widespread belief that defensive practice accounts for a substantial amount of wasted care that is really of no value to patients, says Waxman. "This comes up over and over again in policy debates, when people talk about the need to curb the growth in health care costs," he says. "Every time this conversation happens, tort reform is discussed as a way of controlling costs."

The researchers set out to determine if there is any evidence that such legislation resulted in practice changes in emergency medicine. "Interestingly, there are lots of data to show that EPs believe that they practice defensively," says Waxman.[1]

The laws provide substantial malpractice protection for EPs, says Waxman, because the gross negligence standard is very difficult for plaintiff attorneys to meet. "It is a very high bar," he says. "In terms of the kinds of malpractice reform laws that have been proposed, these laws are as strongly protective as you can imagine."

The researchers don't address the value of tort reforms. "We are not in any way passing judgment on whether these kind of tort reforms are good or bad," notes Waxman. "There are other factors and societal benefits to consider."

Multiple Factors Involved

No EP wants to be sued, says Waxman, but they also don't want to make mistakes, harm patients, or look bad in front of their peers. "It is generally easier to do more testing rather than less," he adds. "If we diminish the risk of lawsuits, EPs still have other forces pushing them in the direction of being conservative and doing more rather than doing less."

If the goal is to change the kind of care that is ordered in EDs or the way EPs practice, says Waxman, the study suggests that malpractice reform alone isn't an effective approach. "I don't think it's such a bad thing for our profession to say it turns out that what we do is driven more by what we think is necessary for patient care, rather than something we are doing out of fear," says Waxman.

Opponents of malpractice reform have argued that if the threat of malpractice is removed, EPs are likely to cut corners and harm patients in the process.

"The flip side of the findings is the fact that care didn't change when these laws were passed," says Waxman. "Emergency physicians didn't suddenly start getting cavalier." ■

REFERENCE

1. Waxman DA, Greenberg MD, Ridgely S, et al. The effect of malpractice reform on emergency department care. *N Engl J Med* 2014;371:1518-1525.

SOURCE

- **Daniel Waxman**, MD, RAND Health, Santa Monica, CA/Department of Emergency Medicine, University of California, Los Angeles. Phone: (310) 393-0411, ext. 7259. E-mail: dwaxman@rand.org.

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.

COMING IN FUTURE MONTHS

- Update on state laws changing ED malpractice standard to gross negligence
- Crucial factors to consider when choosing a medical malpractice attorney
- Why nursing notes can unexpectedly complicate emergency physician's defense
- Avoid getting roped into malpractice suit against one of your ED colleagues

ED LEGAL LETTER™

CNE/CME INSTRUCTIONS

To earn credit for this activity, please follow these instructions:

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

2. Scan the QR code, or log on to www.cmecity.com to take a post-test; tests are taken after each issue. After January 5, 2015, log onto AHCMedia.com and click on MyAHC. 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 completed evaluation is received, a credit letter will be e-mailed to you instantly.

CNE/CME QUESTIONS

1. **Which of the following practices is recommended for emergency physicians to reduce liability risks, according to John Tafuri, MD, FAAEM?**

   A. Encourage patients not to overreact regarding the seriousness of their symptoms.
   B. Avoid posting white boards in patient rooms to let them know the status of ordered tests.
   C. Never specify average wait times for various tests or specialty consultations.
   D. Make a follow-up call to address unresolved concerns if a patient leaves the ED dissatisfied or has an unexpected bad outcome.

2. **Which of the following is recommended to reduce the likelihood of ED malpractice claims, according to William M. McDonnell, MD, JD?**

   A. Provide patients with an outlet for their anger and frustration before they leave the ED.
   B. Avoid adopting formal disclosure, apology, and compensation programs.
   C. Never involve risk-management or insurance carriers early if a suit is possible.
   D. Discuss details of an event, and potential litigation, with nurses or consultants involved in the patient's care.

3. **Which is true regarding reporting requirements to the National Practitioner Data Bank?**

   A. No reporting is required if cases are resolved under state programs designed to settle the matters outside of court.
   B. All medical malpractice claims that include a written demand for payment must be reported.
   C. A report is always required, even when a compensation offer is initiated by an emergency physician and no written demand for payment is made.
   D. There is no distinction made between written claims and claims for payment in a non-written form.