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From the publishers of *Emergency Medicine Reports* and *ED Management*

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IN THIS ISSUE

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Judicial temperament: Why it matters to emergency physicians

Robert A. Bitterman, MD, JD, FACEP, Contributing Editor

In the turmoil of President Bush's recent nominations for the U.S. Supreme Court there has been a great deal of discussion concerning judicial philosophy or judicial temperament. The issue is whether judges are purely interpreting the law or actually 'making new law,' often called 'judicial activism.' The prevailing precedent is that judges should not make law or legislate from the bench, but instead should interpret and enforce the laws as written by the branch of government elected by the people.

An unfortunate example of why judicial restraint matters a great deal is the recent decision by the Wisconsin Supreme Court, in the case of *Ferdon v. Wisconsin Patient Compensation Fund*[1] declaring the legislature's cap on non-economic damages in medical malpractice cases to be unconstitutional.

In 1995, Wisconsin had enacted a comprehensive statutory scheme of tort reform to address the medical liability crisis and access to care issues. It required physicians and hospitals to maintain liability insurance and also created a Patient Compensation Fund, financed by mandatory assessments on health care providers, to provide coverage for patient damages in excess of the statutory amount of insurance carried by the providers.

Any individual harmed could recover an unlimited amount of economic damages (including all lost income and medical expenses) from the physician, up to his or her amount of coverage, and any amount remaining would be paid out of the Fund. However, the legislature decided to limit non-economic damages (typically unquantifiable injuries such as pain and suffering) to $350,000, indexed to inflation (which raised the amount to $445,775 by 2005).

When enacting the reforms, the legislature specifically listed a number of objectives and findings that were the basis for enacting the statute and cap on non-economic damages. Its general objectives were to: (1) reduce the size of medical malpractice judgments and settlements to tame the cost of medical malpractice insurance, and (2) make the choice to practice medicine in Wisconsin desirable so that quality health care will be readily available in the state.[1]

Some of the legislature's specific fact findings were:

- The cap reduces the size of malpractice awards and malpractice insurance premiums.

- The cap protects the patient compensation fund's reserves and allows the fund to keep provider assessments to a reasonable level.
- The cap encourages providers to stay in Wisconsin, reduces the practice of defensive of medicine, and reduces the overall cost of health care to our citizens.
- Medical malpractice judgments and settlements have increased substantially, causing many liability insurance companies to cease providing malpractice insurance, and discourage young physicians to practice medicine in the state or cause health care providers to curtail or quit practices in Wisconsin.[1]

The Wisconsin Supreme Court, however, determined that the statute's non-economic damages cap violated the equal protection guarantees of the Wisconsin constitution.[1]

Normally a statute challenged on equal protection grounds is presumed to be constitutional "because statutes embody the economic, social, and political decisions entrusted to the legislature," and the party challenging its constitutionality must demonstrate it is unconstitutional beyond a reasonable doubt. If there is any doubt, the court must uphold the statute, and the court is supposed to give 'great weight' to the findings of the legislature.

The standard of review typically used to determine if statutes such as tort reform are constitutional is called the *rational basis test*. This standard means that if the legislature had any rational basis for its stated findings and purpose in enacting the statute, it meets constitutional muster. It is extraordinarily rare for a court to overturn a statute by asserting, beyond a reasonable doubt, that the legislature had absolutely no rational basis for enacting the statute; but that is exactly what the Wisconsin Supreme Court decided.

The judges began by stating "the court must presume that the legislature's judgment was sound and look for support for the legislative act," and that "a statutory discrimination will not be set aside if any state of facts reasonably may be conceived to justify it."[1] The majority also acknowledged that the rational basis test does not require the legislature to choose the best or wisest means to achieve its goals; it simply has to have a plausible policy reason for a legitimate legislative purpose.

However, instead of searching the facts for those that justified the legislature's action, the court did exactly the opposite. It conducted its own investigation into the facts, its own review of the published literature and studies on the impact of non-economic damage caps, its own accounting analysis of the Patient Compensation Fund's finances and then, as noted by the dissenting opinion, simply substituted its findings for those made by the legislature to conclude that Wisconsin's cap was unconstitutional.

The majority opinion held that it was not reasonable to believe that a $350,000 cap on non-economic damages reduces malpractice insurance premiums or that the cap was rationally related to the legislature's objective of lowering malpractice premiums. The conclusions of the court were (and compare these to the legislature's finding):

- The non-economic damages cap does not decrease malpractice awards or decrease malpractice insurance premiums.
- The cap would not effect a physician's decision to practice or limit services in Wisconsin.
- The cap would not help reduce the practice of defensive medicine or reduce overall health care costs.
- The cap would not protect the solvency of the Wisconsin Patient Compensation Fund.[1]

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The dissenting opinions noted that the state's judicial precedent "requires only that the reviewing court locate some reasonable basis" for its statutory classifications, prompting one of the dissenting judges to state, "Now, instead of attempting to locate a rationale to support the caps, the majority searches for studies to discredit them."[1] The judges minimized, selectively discredited, or ignored important facts that actually supported the legislators' findings, often from the very same studies the court felt supported its position, such as governmental studies conducted by the U.S. Dept. of Health and Human Services (HHS), the General Accountability Office (GAO), and the Congressional Budget Office (CBO). For example:

- **Malpractice awards and malpractice insurance premiums**

— The GAO conclusively showed that during 2001-2002 states with caps experienced an average premium rate increase of 10%, as compared with a 29% increase in states without caps over the same time period, and that malpractice premiums were lower and grew less rapidly in states with non-economic damage caps.[2,3]

—Wisconsin's own malpractice premiums dropped by 5% during 1991 to 2002, whereas in the same 11-year period the median medical malpractice premiums increased more than 35-50% in other states. In fact, Wisconsin had the lowest loss ratio of any state, around 62%, compared with greater than 100% loss ratios in virtually every other jurisdiction. (Loss ratio is the amount of losses paid by an insurance company related to the amount of premium received. Med-mal companies typically run ratios greater than 100% because of the time value of money: The premium received today isn't used to pay claims until years later.)[1]

— Oregon's experience. In 1998 caps on non-economic damages were ruled unconstitutional in the state of Oregon. Losses had remained steady over the previous 7 years with the cap in place. After removal of the cap, annual losses tripled in less than 3 years.[4]

— The CBO concluded that federal caps on damage awards, in combination with other tort reforms, would reduce malpractice insurance premiums by 25-30% during the 10-year period from 2004 to 2013.[5]

— HHS's Office of Technology Assessment found that caps on damages awards consistently reduced the size of claims, and, in turn, malpractice premium rates.[6]

— Study published by Kenneth Thorpe, former advisor to the Clinton administration on health policy issues, found that medical liability insurance premiums were 17.1% lower in states that had capped court awards.[7]

— The American Hospital Association Professional Liability Insurance Survey found professional liability expenses doubled for nearly half of the hospitals in states experiencing a liability crisis, but were lower in states that had enacted liability reform. The average professional liability expense growth over the previous two years in the crisis states was 158% compared with 74% in the reform states.[8]

— A study by Milliman USA, based on statistics reported to the National Practitioner Data Bank, demonstrated that malpractice losses were below average in states that had laws limiting non-economic damages, while states without these reforms had losses above the national average.[9,10]

- **Attracting more physicians to Wisconsin**

— An HHS study evaluated 49 states during an extended period and concluded that "States with a cap average 24 more physicians per 100,000 residents that states without a cap. Thus, states with caps have about 12% more physicians per capita that states without a cap." The same study found the effect even more pronounced in Wisconsin; the difference was over 25% compared to states without caps.[11,12]

— The American Hospital Association Professional Liability Insurance Survey, March 2003, noted hospitals in malpractice crisis states compared with those in non-crisis states reported considerable more difficulty in recruiting physicians, retaining physicians, providing on-call physician coverage of their emergency departments, and in their ability to maintain specific services such as trauma care or obstetrical care.[8]

- **Defensive practice of medicine costs/overall health care costs.**

— The majority simply ignored a large body of accumulated research that medical malpractice liability causes doctors to practice defensive medicine. It even sidestepped one of the government studies it quoted, missing the fact that the same study determined that the imposition of damage caps would result in "between $9.3 billion and $16.7 billion in additional budgetary savings [to the U.S. government] in 2013 from reduced defensive medicine." [13,14]

— The HHS itself estimated the government would save $28 billion to $48 billion per year in the Medicare and Medicaid programs on defensive costs alone if the malpractice situation was brought under some control.[15]

— The Employment Policy Foundation Study estimated that limiting damage awards in medical liability cases could save $54.8 billion to $97.5 billion annually, or 7.2% to 12.7% of the $765 billion spent on hospital and physician services each year. The report says that rising liability costs reduce access to care and artificially inflate health care expenditures by encouraging medically unnecessary tests and diagnostic procedures. It estimated that curbing medical liability excesses would reduce employer-sponsored health

plan costs by $17.4 billion to $30.9 billion annually, and would reduce the employee share of annual health plan costs by $59 to $109 per employee annually.[16]

- **Effect on the Wisconsin Patient Compensation Fund**

— The Wisconsin Insurance Commissioner's own written conclusion stated that the non-economic damage caps helped control medical malpractice awards and create a stable legal environment in Wisconsin. In fact, a non-partisan legislative actuary study and audit had estimated that "if Wisconsin's cap on non-economic were to be declared unconstitutional, the potential fund liabilities may be increased by an estimated 150-200 million dollars." The audit specifically cited the legislature's re-establishment of a limit on non-economic damages in 1995 as one of the reasons behind the stabilization of the Fund's finances.[1]

Final comment

When reviewing validly enacted legislative acts, the court is supposed to recognize that it is the legislature's function, not the court's, to evaluate studies and reports. The court should not second guess the legislature. In this case the court essentially conducted its own mini trial to independently find the facts, examined only selective evidence that supported its policy perspective rather than that of the legislature, and conveniently ignored evidence that the legislature considered or that did not fit with the court's conclusions.

Furthermore, the court gave no weight to the fact finding of the legislature, instead of the customary great weight, or at least the benefit of the doubt, it is supposed to give to the legislature's decision making, particularly regarding such a contentious and difficult issue.

The statute was an attempt by the legislature to find a balance between compensating victims of malpractice, protecting health care providers from excessive cost of medical malpractice insurance, and ensuring access to quality health care in the state. All those harmed by malpractice were guaranteed recovery of all their economic losses and medical expenses; it was only the unquantifiable damages of pain and suffering that were capped by the legislature. It strains credibility to hold that enacting such a comprehensive medical injury compensation package— which includes caps on non-economic damages to minimize the flow of dollars out of the health care system—doesn't "rationally advance a legitimate legislative objective."

The Wisconsin Supreme Court pledged its adherence to "to the concept of judicial restraint that cautions against substituting judicial opinions for the will of the legislature," but it did exactly the opposite, tossing judicial restraint out the window to 'make new law' by simply substituting its policy preferences for those of the legislature.

Wisconsin now joins Illinois and Ohio, along with a few other smaller states, in invalidating legislatively enacted caps on non-economic damages, in contrast to its neighboring states, Michigan and Indiana, which have declared the caps are constitutional.

Postscript

After the ruling by the Wisconsin Supreme Court, the state's legislature made a number of attempts to reinstate damage caps for medical malpractice cases, and finally reached an agreement with Governor Jim Doyle earlier this year to cap non-economic damages at $750,000. The constitutionality of the higher cap is certain to be challenged court. Stay tuned!

References

1. *Ferdon v Wisconsin Patient Compensation Fund*, 701 N.W.2d 440 (WI 2005).
2. U.S. Government Accountability Office. GAO Report (GAO-03-702). *Medical Malpractice Insurance: Multiple Factors Have Contributed to Increased Premium Rates*. Available: http:// www.gao.gov/new.items/ d03702.pdf. The GAO determined multiple factors, including falling investment income and rising reinsurance costs, contributed to increases in malpractice premium rates, but found that losses on claims were the primary driving factor.
3. U.S. Government Accountability Office. GAO Report (GAO-03-0836) August 2003. *Medical Malpractice: Implications of Rising Premiums On Access to Health Care*. Available: http:// www.gao.gov/new.items/d04128t.pdf.
4. Data from A.M.Best Database Services and the Tillinghast report.
5. U.S. Congressional Budget Office. *Limiting Tort Liability for Medical Malpractice* (January 8, 2004). Available: www.cbo.gov. (See also the CBO report of *The Economics of US Tort Liability: A Primer* [October 2003].)
6. U.S. Department of Health and Human Services Office of Technology Assessment. *Impact of Legal Reforms on Medical Malpractice Costs.* September 1993. Report found that caps on damages awards consistently reduced the size of claims, and, in turn, premium rates for malpractice insurance. See also U.S. HHS Update on the Medical Litigation Crisis: Not the Result of the "Insurance Cycle". November 2002. Available: http://aspe.hhs.gov/daltcp/reports/mlupd2.htm.
7. Thorpe K. *Medical Liability Premiums. Health Affairs.* January 21, 2004. http://www.healthaffairs.org.
8. American Hospital Association Professional Liability Insurance Survey - A Growing Crisis. March 2003.
9. Kipp R, Cookson JP, Mattie LL. *Health Insurance Underwriting Cycle Effect on Health Plan Premiums and Profitability*. Milliman, USA, April 10, 2003.
10. Actuarial and Analytics Practice of Aon's Risk Services, Inc. Aon conducted a hospital professional liability and physician liability benchmark study and concluded that the "real problem" is the growing size of liability awards and that caps do limit award sizes. January 2004. Available: http://www.aon.com.

11. U.S. Department of Health and Human Services. *Addressing the New Health Care Crisis: Reforming the Medical Litigation System to Improve the Quality of Health Care*. March 3, 2003. Available: http://aspe.hhs.gov/daltcp/reports/medliab.pdf.
12. U.S. Department of Health and Human Services Agency for Healthcare Research and Quality (AHRQ). Hellinger FJ, Encinosa WE. "The Impact of State Laws Limiting Malpractice Awards on the Geographic Distribution of Physicians." Available: http:// www.ahrq.gov/research/tortcaps/ tortcaps.htm.
13. Cohen H .Congressional Research Service Report for Congress. *Medical Malpractice Liability Reform: Legal Issues and Fifty-State Survey of Caps on Punitive and Non-economic Damages.* Order Code RL31692 Updated May 14, 2003. Discusses the pros and cons of the malpractice liability reform bill passed by the U.S. House of Representatives, H.R. 5 (The HEALTH Act), on March 13, 2003. It includes a discussion on the effectiveness of caps.
14. U.S. Department of Health and Human Services Report - Confronting the New Health Care Crisis: Improving Health Care Quality and Lowering Costs by Fixing Our Medical Liability System. July 24, 2002.
15. U.S. Congressional Budget Office. Cost Estimate for H.R.5 (Health Act of 2003) March 2003. Based on its own research on the effects of tort restrictions, the Congressional Budget Office (CBO) estimated that provisions of the Health Act of 2003 (H.R.5) would lower premiums nation wide by an average of 25%-30% from the levels likely to occur under current law. Available at www.cbo.gov.
16. Employment Policy Foundation Study June 21, 2003. Available at: http://www.epf.org/. ❑

Sitting down to talk can keep patients from suing

Plaintiff lawyers often "helpful, not harmful"

Staci Kusterbeck, Contributing Editor

At Ann Arbor-based University of Michigan Health System, a "full disclosure of unanticipated outcomes" policy has prevented several threatened malpractice lawsuits involving ED patients. "Emergency medicine cases are difficult because you don't usually get a chance to talk to people who are unhappy but haven't already gone to a lawyer," says **Richard C. Boothman**, the organization's chief risk officer.

Even so, open communication with unhappy patients and their lawyers has stopped several from suing. "We have had a number of threatened emergency medicine cases averted by exchanging information, even to the point of offering the patient's lawyer the chance to interview the doctor involved," says Boothman.

Most patients contact lawyers not out of a "lottery" mentality but because they want answers, says Boothman. He notes that "full disclosure" doesn't always mean an apology—in many cases it takes the form of an explanation.

The organization committed to three principles:

- If care was not appropriate and it caused a patient harm, the patient is compensated reasonably without delay.
- If care was reasonable and/or did not cause any injury, staff are defended vigorously. "Doctors and nurses work in inherently dangerous environments where even the most simple decision—like giving child antibiotics for an ear infection—can result in a life-threatening complication," says Boothman. "If after a thorough evaluation you are confident that your care was appropriate, why not say so upfront before the wheels of a lawsuit are in motion?'
- Patient experiences are considered a valuable resource for continual improvement in the quality of care and patient communication. "We work hard to see patient complaints as a gift —an opportunity to listen, explain, apologize where warranted and most importantly, correct that which should be corrected," says Boothman.

Talk before *suit is filed*

When a patient or his/her attorney comes forward with a complaint, both sides benefit from a free exchange of information before anyone is sued, says Boothman. "At that point in time, our interests are identical to the patient's interests. We both want to know what happened and whether our care was reasonable or unreasonable," he says.

The patient and lawyer won't want to file a lawsuit only to lose the case after investing a lot of money, time, and emotion into it, while the hospital doesn't want to defend a case only to find out it should have

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Key Points

- A policy of "full disclosure" has prevented several ED malpractice lawsuits at a Michigan hospital system.
- Open communication is most effective before a lawsuit is filed.
- Plaintiff attorneys may decide not to proceed with a lawsuit after they learn the facts.
- More than 20 states have passed "I'm Sorry" laws, which protect apologies from being used as evidence in lawsuits.

SPECIAL REPORT

Emergency Physician Contracts: Terms to Ponder

by William Sullivan, DO, JD, FACEP, FCLM, Contributing Editor

Most emergency physicians perform medical services pursuant to some type of written provider agreement. Whether an employment contract or an independent contractor agreement, these provider agreements establish a physician's rights, responsibilities, and legal liabilities. Unfortunately, some physicians fail to realize that some contract terms can have a significant adverse effect on their legal rights. Once a contract is signed, both parties must abide by the terms – even if the terms were not clearly understood when the contract was signed. Failing to adhere to contractual responsibilities, or "breaching" the contract, may make the breaching party responsible for monetary damages. For this reason, it is important to understand a contract before signing it and to eliminate unfavorable terms when possible. Below are some of the more commonly litigated contract issues.

Malpractice Insurance

Full payment of malpractice insurance premiums is a standard provision in almost every emergency medicine contract. When reviewing a contract, two issues regarding malpractice insurance are important.

Coverage Limits. Unless state statutes require less coverage, standard professional liability policy limits should be at least "$1 million/$3 million," meaning that there is a $1 million limit for a single incident and $3 million limit per year. Be careful since often contracts will not state specific limits and malpractice insurance policies can have limits as low as $100,000/$300,000. If a contract does not specifically state coverage limits, in the absence of statutory requirements to the contrary, lower malpractice policy limits may be insufficient to protect a physician's assets. For example, if policy limits are $1 million/$3 million and there is a judgment against the physician for $500,000, the policy would entirely cover the judgment. If instead the physician only had policy limits of $100,000/$300,000, the physician would have to pay $400,000 of the judgment from personal assets. As one example, see *American Physicians Assurance Corp. v. Schmidt*, 187 S.W.3d 313 (2006) where a physician was left responsible for paying more than $800,000 of a judgment in excess of his insurance policy limits when he did not accept settlement offers for the policy limit of $1 million. Fortunately, in this case the physician was able to negotiate terms of a settlement that did not require him to pay money out of personal assets.

Insurance Type. There are two basic kinds of professional liability insurance coverage. *Occurrence-based* insurance depends upon when an alleged act of malpractice "occurred." As long as the policy is in effect at the time the incident occurred, the physician is covered for the claim. *Claims-made* coverage protects a physician only if it is in force when an alleged act of malpractice occurred and when the company receives notice that a "claim is made" against the physician. This is an important distinction and underscores the importance of promptly reporting potential malpractice claims to your insurer.

In T*horacic Cardiovascular Associates v. St. Paul Fire and Marine Insurance Co*., 891 P.2d 916 (1994), a group of physicians dropped their claims made insurance policy and declined "tail insurance" offered by the insurer. The insurance policy lapsed on February 16, 1988. Unbeknownst to the group, a malpractice lawsuit had been filed against the group on October 15, 1987, but the group was not served with notice of the lawsuit until July 12, 1988 – almost five months after the group's malpractice insurance policy lapsed. When the group reported the claim to the insurer, the insurer refused coverage, stating that the claim was reported after the insurance policy had lapsed. The appellate court agreed, holding that the plain language of the insurance contract required a claim to be reported to the company within the policy period in order for coverage to apply. Since the claim was reported after the policy lapsed, even though the claim was filed during the policy period, the insurance company was not required to insure the group.

The case *President v. Jenkins*, 814 A.2d 1173 (2003), contains a comprehensive discussion about an obstetrician who failed to pay malpractice premiums while securing another malpractice policy and who later discovered he had no coverage for a claim that occurred between the end of one occurrence-based policy and the beginning of a second claims-made policy.

Tail insurance, also called *extended reporting coverage*, is a way to stay insured when a claims-made policy ends. Tail insurance is a lump-sum premium paid to the insurance company that secures coverage for future claims. An easy way to understand the concept of tail

insurance is the general equation that "claims made policy + tail insurance = occurrence based policy." Tail insurance is quite expensive – often costing $40,000 or more for emergency physicians. Look elsewhere if an emergency medicine contract does not offer either occurrence-based insurance or claims made insurance with full tail coverage.

Restrictive Covenants

Restrictive covenants can be divided into non-compete clauses and non-solicitation clauses. Both are designed to keep one contracting party from damaging the business interests of the other contracting party. In medical contracts, non-compete clauses attempt protect established medical practices from contractors who leave and then try to take the practice's patient base with them. For example, a clinic that spent 20 years developing a patient base could lose a large number of patients if a well-liked physician leaves and sets up a practice across the street. Non-compete clauses may also attempt to keep a former contractor from attempting to outbid a former group for a service contract with a hospital. Non-solicitation clauses generally attempt to prevent a former contractor from hiring a group's employees once the contractor leaves.

Each state has different criteria for enforcing restrictive covenants. In general, restrictive covenants must be reasonable in scope and duration, must protect some cognizable business interest, must not prohibit a contracting physician from pursuing activities not engaged in by the employer, and must not violate public policy. A majority of the published cases regarding contract actions against emergency physicians involve restrictive covenants. In none of the cases has a court decided against the emergency physician. For example, in *Duneland Emergency Physician's Medical Group v. Brunk,* 723 N.E.2d 963 (2000), the Indiana Court of Appeals held that a restrictive covenant against an emergency physician was unenforceable because a group has no protectable business interest in a former employee that leaves to work for a competing group. In its opinion, the court noted that patients did not "select a hospital emergency room based on which physicians worked there" and therefore preventing a physician from working in a competing emergency department served no legitimate purpose.

In *Premier Health Care Services, Inc. v. Schneiderman,* 2001-Ohio-7087 (2001), the Ohio Court of Appeals held that once a group's contract to provide emergency services at a hospital terminates, it no longer has a legitimate business interest in preventing former employees from working at the hospital. Additionally, in this case the court held that dismissal of all the emergency department staff physicians from a Level I trauma center would adversely affect medical care and was therefore against public policy. The restrictive covenant preventing the group's physicians from working in the hospital after the termination of the group's contract was therefore considered invalid.

Emergicare Systems Corp. v. Bourdon, 942 S.W.2d 201 (1997) held a restrictive covenant against an emergency physician as unenforceable – in part because it prevented the defendant from continuing to serve the public as an emergency physician.

In addition to legal precedent, several professional organizations have policies against restrictive covenants. The American Bar Association's Rules of Professional Conduct Rule 5.6 prohibits restrictive covenants in attorney contracts. While the American Medical Association currently discourages restrictive covenants, the latest revision of the AMA's Council on Ethical and Judicial Affairs Opinion E-9.02 seeks to permit restrictive covenants in physician contracts under certain circumstances. ACEP Policy #400284 condemns restrictive covenants in physician contracts as being against the public interest.

Even though restrictive covenants may be difficult to enforce against emergency physicians, litigating their enforceability may be costly. When possible, it is better to remove restrictive covenants prior to signing a contract, or to at least limit a restrictive covenant's applicability. Presenting the considerable amount of legal precedent against enforcing restrictive covenants may be useful in persuading a group to delete a restrictive covenant from its contract.

Conclusion

Understanding some of the more common contract terminology can help a physician create a contract that protects both parties. When in doubt about whether a contract may be right for you, hire an attorney to assist you. ❑

Future Issues: More emergency medicine contract concerns; patients leaving against medical advice; HIPPA and the ED.

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been settled. "Plaintiff lawyers are often helpful, not harmful, in this situation," says Boothman. "Most lawyers thank me even when we tell them they don't have a case, because it keeps them from making a costly mistake."

But the dynamics change once a lawsuit is filed, since the attorney is ethically obligated to pursue it as long as the client wants to continue, so long as he has an expert to support the case. "Once they invest money, the tendency to keep the case going is huge, if for no other reason than to get their money back," says Boothman.

In one case, a girl was brought to the ED with difficulty breathing after her tracheostomy had been resized. The ED physician wanted to keep her for further evaluation, but the mother left against medical advice when the child became stable and calm. The girl was found in the morning dead, and the parents contacted a lawyer. The ED physician sat down with the patient's lawyer and reviewed every step in the process.

"Several details about the child and her condition when she was found did not appear in the medical record. So we sat at length and went over all the details and all the reasons why the doctor did what she did," says Boothman.

After the discussion, the plaintiff's lawyer became convinced that there was nothing negligent in the child's care. "I'm convinced that the doctor's own emotional response—she was obviously deeply saddened by the baby's death—made as much of a difference as any information we were able to give," says Boothman.

In some cases, patients may simply want to know that something has been done about their complaint. In a case of failing to diagnose ectopic pregnancy, the patient was persuaded that the ED was not at fault because the OB-GYN service had already accepted the referral. "That experience caused us to tighten up both documentation and follow-up protocols at that outlying hospital," says Boothman.

ED physicians like policy

The response by the ED staff and physicians has been "overwhelmingly positive," according to **William G. Barsan**, MD, chair of the department of emergency medicine.

One reason is that physicians feel less "victimized" and have a greater sense of control because they are included in the process from the very beginning. After the physician is asked for input, all cases are brought before the medical liability review committee, which consists of medical staff members.

"This is essentially a jury of your peers, and they are very honest," says Barsan. "Regardless of the fact that you may be a fellow faculty member, if they don't think the standard of care has been met they will say so."

Although ED staff are free to consult with risk managers, there is no hard and fast rule that they must do this before speaking with a patient. "If appropriate, most of us usually like the opportunity to do something like that," says Barsan.

For instance, if the patient received 250 mg of an antihistamine instead of the 50 mg that was ordered, physicians will generally tell the patient about the mistake right away. "We tell them what happened, why it happened and what we're going to do to make sure it doesn't happen again," says Barsan. "Just because patients don't notice a mistake, it's not necessarily the right policy not to bring it to their attention."

The number of lawsuits has decreased in hospitals with full disclosure and apology protocols, and there is a reduction in settlements and litigation expenses, says **Joseph J. Feltes**, a Canton, OH-based attorney with Buckingham, Doolittle & Burroughs, LLP.

"People appear much more willing to forgive if physicians and hospitals are forthcoming and candid when discussing an unexpected clinical outcome, and express a genuine statement of apology, sympathy, commiseration, condolence, or compassion," says Feltes.

Consider the following items before talking with your patient about a medical error:

• Know your state laws.

A growing number of states have passed "I'm Sorry" legislation, which means that sincere expressions of condolence cannot be introduced as evidence in a trial. At press time, these states are Arizona, California, Colorado, Florida, Georgia, Hawaii, Idaho, Illinois, Maryland, Massachusetts, Montana, North Carolina, Ohio, Oklahoma, Oregon, Texas, Tennessee, Vermont, Virginia, Washington, West Virginia and Wyoming.

Since state laws vary, it's important to know exactly what is protected under your state's law. For example, Ohio's statute protects general expressions of sympathy such as "I'm sorry things did not go as we had hoped," whereas Colorado's law goes a step farther by allowing an ED physician to admit fault and accountability, which cannot be introduced at trial.

• Get advice.

If you have any concerns about meeting with a patient or their family, first contact your risk manager, legal counsel, or insurance carrier for guidance, says Feltes.

"The situation for an ED physician is different from

one where there is a long-standing relationship between the physician and the family," adds Feltes. The ED physician needs to be involved and participate in the discussion, but it might be more appropriate for the hospital's risk manager to take the lead, he says.

• Contact the patient promptly.

Once the patient files a lawsuit, the "I'm Sorry" statutes no longer apply. This is one reason to contact the patient sooner rather than later, says Feltes. "The longer a physician waits, the more uncaring and evasive he or she may be perceived as being. Time allows feelings to fester and anger to mount and harden," he says.

However, Feltes recommends waiting a day or two for emotions to settle down, giving you time to obtain legal advice and do a more thorough investigation of the facts.

• Don't necessarily admit wrongdoing.

Be factual, candid, sincere and forthcoming in explaining what happened and answering questions, says Feltes. "It is not necessary for physicians to 'fall on their sword' by accepting responsibility or blame when they did not make a mistake," he says.

Sometimes the only thing you need to say is a statement such as "I'm sorry about your loss," says Feltes. "Expressions of sympathy do not equate to admissions of wrongdoing," he notes. ❑

Handling hostile lawyers during depositions

Don't let tension impact your statements

Staci Kusterbeck, Contributing Editor

When being verbally confronted during a deposition, you may be tempted to blurt out a statement you may later regret. "Do not let the opposing attorney get you rattled by intimidation. Usually they are trying to get the witness to lose their cool," says **Kathryn Eberhart**, BSN, RN, CEN, a Santa Rosa, CA-based legal nurse consultant and ED nurse at Santa Rosa Memorial Hospital.

If an attorney goes into "attack mode," recognize what he or she is doing and don't let it get to you, says **Jonathan D. Lawrence**, MD, JD, FACEP, an ED physician and medical staff risk management liaison at St. Mary Medical Center in Long Beach, CA.

"This just frustrates the bully even more. Take a deep breath and wait before blurting out a possibly unwise spontaneous response," he says.

Here are tips for depositions:

• Don't answer questions you don't understand.

"If you are asked a question that you do not understand, say so," says Eberhart. "If you don't have a memory of an incident, say "I don't recall."

• Take action if the lawyer is hostile.

If the attorney representing you is doing his/her job, the opposing attorney won't be able to get away with harassing and overtly hostile behavior, adds Lawrence. Repeated warnings to "tone things down" that go unheeded will cause your attorney to threaten to terminate the deposition and go to a judge to impose sanctions.

"Remember your attorney is there to prevent his or her client from being subjected to harassing or overly hostile questioning. If your attorney is not doing their job, ask for a break, step out of the room, have a conference and express your concerns," says Lawrence.

• Correct yourself right away.

If you say something you regret, such as an outburst made in frustration, you can make a correction on the record, or you can change the transcript at a later date when you review it. "Both of these methods can be commented upon by opposing counsel at time of trial if they so desire. So the best policy is to think out all your answers and not be forced into making corrections," says Lawrence.

It is more damaging to the case to correct a statement after the deposition is over, says Eberhart. "If you realize that what you said may have been misconstrued, just tell the attorney you want to clarify a statement you made that may be confusing or not correct. It is better if you do this while you are still in the deposition," she says.

• Ask for a break.

There may be state specific rules, but on a general basis, the opposing attorney can't refuse you a break, says Eberhart. "You can always say 'I need to use the restroom,' or 'I'm tired, I need a break,'" she says.

• Answer the questions.

Don't answer a question unless it's asked, and never give more information than asked for, says Eberhart. However, it won't help your case if you are evasive and fail to answer the question being asked. "That type

Key Points

During depositions, keep your composure even if things become heated.

- Ask for a break.
- Don't answer questions you don't understand.
- Correct misstatements on the record during the deposition.

of deposition may raise suspicion and make the other side dig further," she says.

For instance, there have been several cases where an emergency nurse continues to say 'I don't know,' even when asked questions about policies and procedures and his/her own state nurse practice act. "The nurse should know the policies and procedures of the ED they work in, and when asked if they have seen a specific policy they should be answering yes," says Eberhart. "However, if they don't remember one, that's a valid response."

It can also appear that the nurse is "not the sharpest tool in the shed" when asked specific questions about his/her practice area, says Eberhart. "I've seen this in multiple different depositions," she says. "If you don't remember, you don't remember. However, the nurse should remember what they do clinically and they can say 'I don't remember, but my usual standard of practice is X,Y, and Z.'"

Not all legitimate questions are "soft balls," warns Lawrence. "Questions may be difficult to answer and may make you sweat," he says. A pointed question would be: "Dr. X, did you consider the possibility of child abuse when you discovered the skull fracture?" But this could also be framed as "Dr. X, wouldn't any reasonable physician have considered child abuse upon discovering the skull fracture?"

"The defense attorney should object to this question on any or all of the grounds that it is overbroad, argumentative, or calling for expert opinion—and not allow the doctor to answer," says Lawrence.

Although you may be tempted to confront a hostile attorney by stating "You seem angry," the smartest response is to remain calm and answer the questions, says Eberhart. "The attorney on the opposing side will attempt to use whatever they can, to get you to answer a question the way they want you to," she says.

This is why it's better to resist the urge to verbally "spar" with attorneys or ask them why they are so angry, adds Lawrence. "Far from jousting with the hostile plaintiff attorney, the physician should not react emotionally at all. Often the histrionics are designed to see what pushes the physician's buttons," he says. ❑

Know facts about liability of residents, attendings

Lawyers will sue all involved

Staci Kusterbeck, Contributing Editor

An ED attending physician discharged a mutual patient prematurely and inappropriately while the resident was involved with another patient. A resident claims he was "just following orders" that led to an adverse outcome. Who will be named in these ensuing malpractice cases?

As a general rule, the answer is "both." "Plaintiffs attorneys will take the path of least resistance and most dollars in almost any medical malpractice case," says **Monte F. James**, head of the medical malpractice section for Texas-based Jackson Walker.

In general, plaintiff's attorneys want to incorporate as many parties as possible to get at more insurance money, says Rice. "So they never want to leave anybody out, unless there is a specific reason that helps their case to leave them out," says **Matthew M. Rice**, MD, JD, FACEP, chief medical officer at Northwest Emergency Physicians of TeamHealth in Federal Way, WA.

Attending physician most vulnerable

Generally speaking, the most vulnerable individual is going to be the attending physician, because he/she is always going to be seen as supervising the resident, says Rice. While a resident may not be liable if his/her name isn't anywhere on the patient's chart, an attending physician will probably be named even if he/she wasn't directly involved in the case but one of the residents the attending physician was supervising was involved, he explains.

Even if the resident is the one who made the mistake, the plaintiff's attorney will focus attention on the attending physician's failure to properly monitor and train that resident, says James.

A possible exception to this rule: If the resident is performing skills within his/her scope of practice, and did not require by policy or national standards to have direct supervision at the time. For example, if the resident is placing an intravenous catheter in a patient's arm and it perforates a nerve and results in nerve damage, the resident would probably be sued. But you could argue that the attending physician should not be included in this case because it is a common task not requiring supervision. "But would you get the attending physician dismissed? Probably not." says Rice.

The plaintiff's attorney still would involve the attending physician on the grounds that he/she should have been supervising that resident, says Rice. "Whether they can include them or not would be worked out in the initial process of litigation. The request by the attending physician that they be dismissed—if they didn't know about the case and there's nothing that suggests they should have—is a legal battle."

A competent plaintiff's lawyer will be able to shift the blame to whichever physician is advantageous for the case, says James. "If the attending physician does

not have good insurance coverage, the lawyer will focus more on the resident, and vice versa," he says.

A common tactic is to ask the attending physician dozens of questions about the patient's condition. When the attending physician inevitably admits being unaware of several items, he/she will ask whether anything would have been done differently if all the facts were known.

"A lot of times the physician will be honest and say 'Yes, if I knew all that, I would have done something differently,'" says James. "So at that point, it puts the resident back in the hot seat for not fully informing them."

Just following orders?

If a resident claims he/she wasn't negligent because he/she followed the advice of the attending physician, the resident would probably not be dismissed from the case, but this is a legitimate defense, says James. "They could certainly defend the case by saying 'I'm a lowly resident and did exactly what my attending told me to do.' That's something the jury will have to decide."

Is "I was just following orders" ever a valid response from the resident? Only to a certain extent, says Rice. "A resident should have some ability to think about what they are being asked to do, and question it if they think it's wrong," he says. "Although the captain of the ship is ultimately responsible, you still want to include the members of the crew."

The difficulty then becomes how to keep the resident from becoming a witness against the attending physician. "For example, if the resident says 'I didn't know if it was right or not, but I did it because the attending physician told me to', then the resident would be a witness against the attending if things don't turn out right," says Rice. "Although that may be accurate, it is not a logical defense from a purely legal point of view."

Key Points

In most cases, both the attending and resident will be named in malpractice cases, even if the error was caused by one individual.

- Attending physicians may be liable even if not involved in the patient's care.
- Once named in a lawsuit, physicians are not likely to be dismissed.
- Lawyers will shift blame depending on insurance coverage.

The resident could ask to be dismissed from the case on the grounds that the final care was provided by the staff physician, but the chances would be slim unless the resident never saw the patient, says Rice. If the resident is dismissed and information later comes up involving that resident, the lawyer might have a difficult time getting him reinstated as a defendant, he explains. "It's much easier just to keep them in than to dismiss them and then try to reinclude them," says Rice.

Residents may fall under sovereign immunity, but that will depend on whether the resident's training program is affiliated with the state in some respect, such as a city or county-owned hospital, says James. If the resident is a member of a private training facility, then sovereign immunity would not apply. However, if the resident comes from a public entity but goes to a private facility to practice, plaintiff attorneys will allege legal theories, such as joint venture, to attempt to make the private entity liable for the resident's activity. "They are trying to get around sovereign immunity, and it's something you see in all 50 states," says James.

To protect residents from liability exposure, you can

CE/CME instructions

Physicians and nurses participate in this CE/CME program by reading the issue, using the references for research, and studying the questions. Participants should select what they believe to be the correct answers, then refer to the answer key to test their knowledge. To clarify confusion on any questions answered incorrectly, consult the source material. After completing the semester's activity, you must complete the evaluation form provided and return it in the reply envelope to receive a letter of credit. When your evaluation is received, a letter of credit will be mailed to you. ■

CE/CME objectives

After completing this activity, participants will be able to:

1. Identify legal issues relating to emergency medicine practice;
2. Explain how these issues affect nurses, physicians, legal counsel, management, and patients.
3. Integrate practical solutions to reduce risk into the ED practitioner's daily practices. ■

provide written notices to patients that the resident's independent medical judgment is limited to what the training physician ultimately allows. "You can put that in writing and have the patient sign. That would not get the resident dismissed, but it would go a long way in proving that the resident was not negligent, assuming the attending's orders were followed," says James. ❑

Future Issues: Who is liable under what circumstances and what can be done to reduce risks.

CE/CME *Questions*

39. Which of the following events occurred at University of Michigan's ED after a "full disclosure" policy was implemented?
    A. The number of lawsuits involving ED patients increased significantly.
    B. Outcomes were only positive if lawyers were not yet involved.
    C. ED staff refused to follow the policy due to liability concerns.
    D. Several threatened malpractice lawsuits were avoided.

40. Which of the following is recommended when being questioned during a deposition?
    A. Refuse to answer questions that put you on the defensive.
    B. If you need to clarify a statement, do so on the record.
    C. Wait until after the deposition is over to correct misstatements.
    D. Avoid asking for breaks, even if things get heated.

41. Which of the following statements regarding liability for malpractice cases involving a resident and attending physician is/are true?
    A. The attending physician can be named even if he or she was not involved in the patient's care.
    B. The resident physician will be dismissed if the attending physician was supposed to be supervising the resident.
    C. The attending physician is only named if physically present during the patient's care.
    D. Residents are not liable if they were following the attending physician's orders.

42. Which of the following statements about malpractice insurance is/are true?
    A. Claims-made coverage protects a physician only if it is in force when an alleged act of malpractice occurred.
    B. Occurrence-based insurance protects a physician if the policy is in effect at the time the incident occurred.
    C. Claims-made coverage protects a physician only if it is in force when an alleged act of malpractice occurred and when the company receives notice that a claim is made against the physician.
    D. Both B and C are correct.

43. The Employment Policy Foundation Study:
    A. estimated that limiting damage awards in medical liability cases could save 7.2% to 12.7% of the $765 billion spent on hospital and physician services each year.
    B. says that rising liability costs reduce access to care
    C. says that rising liability costs artifically inflate health care expenditures.
    D. All of the above statements are true.

Answers: 39. D; 40. B; 41. A; 42. D; 43. D