ED Legal Letter™

The Essential Monthly Guide to Emergency Medicine Malpractice Prevention and Risk Management

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

AHC Media LLC

IN THIS ISSUE

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: Larry Mellick, MD, MS, FAAP, FACEP, (executive editor) Professor of Emergency Medicine and Pediatrics, Residency Program Director, Department of Emergency Medicine, Medical College of Georgia, Augusta; Theresa Finerty, MS, RN, CNA, BC, (nurse planner) Director, Emergency and Trauma Services, OSF Saint Francis Medical Center, Peoria, IL; Staci Kusterbeck (contributing editor); William Sullivan, DO, JD, FACEP, FCLM, (contributing editor) Director of Emergency Services, St. Mary's Hospital, Streator, IL; Clinical Instructor, Dept. of Emergency Medicine, Midwestern University, Downers Grove, IL; Clinical Assistant Professor, Dept. of Emergency Medicine, University of Illinois, Chicago; Sullivan Law Office, Frankfort, IL; Martha Jo Dendinger (Managing Editor) and Glen Harris (Editorial Group Head). Robert Bitterman, MD, JD, FACEP, (contributing editor) discloses that he is President, Bitterman Health Law Consulting Group, Inc., Charlotte, NC; and he serves on the Board of Governors and committees of the Emergency Physicians Insurance Co., Inc., Auburn, CA.

NOVEMBER 2006

VOL. 17, NO. 11 • (pages 121-132)

Hospital not liable for sleep-deprived intern's motor vehicle crash

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

In the case of *Brewster v Rush-Presbyterian-St. Luke's Medical Center,*[1] the appellate court of Illinois had to decide whether a hospital owes a duty to a person injured by an off-duty intern suffering from sleep deprivation due to the hospital's policy on working hours.

Plaintiff Brewster alleged that the hospital's intern, just two weeks into her training, was driving home from the hospital following a scheduled 36-hour work shift when she fell asleep at the wheel of her car. She crashed into Ms. Brewster's car, injuring Ms. Brewster.

The plaintiff presented three theories of liability to sue the hospital for the intern's negligence. First, Brewster alleged the hospital knew or should have known that the intern worked 34 of the 36 scheduled hours, and that the lack of sleep would impair her judgment and ability to drive. Therefore, the hospital had a common law duty to control the actions of the intern to protect Ms. Brewster from harm. Second, the hospital was guilty of negligence under the duty imposed by the 'Restatement (Second) of Torts' (which is a compilation of proposed uniform tort rules, similar to the Uniform Commercial Code [UCC] for business transactions, adopted in whole or in part by state courts or legislatures into their own tort laws).[2] Third, the hospital violated the Illinois Hospital Licensing Act[3], which specifically incorporates the duty hour requirements established by the Accreditation Council for Graduate Medical Education (ACGME).[4]

Common law negligence

Brewster conceded that there was no existing Illinois law that would support a finding by the court that the hospital owed her a duty to protect her from the intern's negligent driving. Instead, Brewster argued that 'public policy' considerations dictated that the court create and impose such as duty upon the hospital. Interestingly, the Committee of Interns and Residents filed a brief (*amicus curiae* - 'friend of the court' – brief) supporting the plaintiff's attempt to expand the hospital's liability. The committee provided data that hospitals know, or reasonably should know, that a high percentage of interns and residents fall asleep behind the wheel of a car when driving home from work at the hospital. It also provided studies demonstrating the hazards of turning loose exhausted interns on an unsuspect-

ing public, both in and out of the hospital. (The committee's transparent motive, besides blaming the hospital for the intern's falling asleep at the wheel, is to force hospitals to decrease the number of work hours imposed on physicians in their training programs.)[5]

Naturally, the Cook County and the Illinois Hospital Association filed briefs on behalf of the hospital, arguing that the hospital should not be liable for the intern's negligent acts when she was not actually working at the hospital. What the intern did on her own time (what little of it she had), should be her responsibility alone.

The court cited four factors relevant to deciding whether public policy should impose a duty of care on the hospital: (1) the reasonable foreseeability of injury; (2) the likelihood of injury; (3) the burden of guarding against injury; and (4) the consequences of placing that burden on the hospital.[6]

Plaintiff contended that an analysis of these factors weighed heavily in her favor. It certainly is reasonably foreseeable and likely that sleep-deprived drivers will cause traffic accidents and injure others. Hospitals could prevent such injuries by changing resident work schedules or providing additional rest periods, and the burden of these preventative measures is minimal when compared to the societal benefit that would be realized.

In essence, the plaintiff was arguing that these factors should induce the court to transfer the negligence of the intern to the hospital, what the law terms '*transferred negligence*'.

However, the court stated that the general common law rule—established in a long line of Illinois Supreme Court cases—was that there is no liability imputed to health care providers for injuries to third parties who are not patients in the hospital.[8] Only if a sleep-deprived intern hurt one of the hospital's patients, then the hospital would be liable.

The appellate court noted it was not a legislative body (i.e., not allowed to legislate from the bench) and that it was duty bound to follow the precedents declared by the state's highest court.

Restatement (Second) of Torts

Brewster next argued that the court should allow the transferred negligence under the Restatement (Second) of Torts.[2,8] However, the Illinois high court did not adopt the entire Restatement; the sections it incorporated into Illinois law allow for transferred negligence only where a 'special relationship' exists between the defendant and the person causing injury or between the third party and the person causing injury. In other words, the hospital must have a special relationship with the intern or the person injured (Brewster), before the hospital has a duty to control the intern's behavior. Under the Restatement, special relationships that give rise to such a duty include, among others, a parent-child relationship and a master-servant relationship. Parents have a duty to control the behavior of their minor children; if one of their kids throws a rock through your kitchen window, the parents are liable. Similarly, hospitals (masters) as employers of interns (servants) are liable if one of their interns sticks a chest tube into the spleen of a trauma patient. However, this 'special master-servant' relationship ends when the intern leaves the hospital; it does not extend outside of the employment relationship.

Note how this applies to practicing emergency physicians. If the emergency physicians are employed by the hospital, the hospital is directly liable for the physician's negligence in caring for patients *in the hospital or the ED*. However, if the emergency physicians are independent contractors or employees of a separate corporation or contract management group that contracts with the hospital to provide ED services,

ED Legal Letter™, ISSN 1087-7347, is published monthly by AHC Media LLC, 3525 Piedmont Road N.E., Bldg. 6, Suite 400, Atlanta, GA 30305. Periodicals postage paid at Atlanta GA 30304. **POSTMASTER:** Send address changes to ***ED Legal Letter,*** P.O. Box 740059, Atlanta, GA 30374.

Subscriber Information: Customer Service: (800) 688-2421Customer Service E-Mail Address: customerservice@ahcmedia.com. Editorial E-Mail Address: martha.dendinger@ahcmedia.com. World Wide Web: http://www.ahcmedia.com. Subscription Prices: United States: $499 per year. Multiple Copies: Discounts are available for multiple subscriptions. For pricing information, call Steve Vance at (404) 262-5511. 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.

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 educational activity for a maximum of 18 *AMA PRA Category 1 Credits™*. Physicians should only claim credit commensurate with the extent of their participation in the activity.

Approved by the American College of Emergency Physicians for 18 hours of ACEP Category 1 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 18 nursing contact hours using a 50-minute contact hour.

Provider approved by the California Board of Registered Nursing, Provider # 14749, for 18 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.

Vice President/Publisher: Brenda Mooney
Editorial Group Head: Glen Harris
Managing Editor: Martha Jo Dendinger
Contributing Editors: Robert Bitterman, MD, JD, FACEP, Staci Kusterbeck, William Sullivan, DO, JD, FACEP, FCLM.

AHC Media LLC

Questions & Comments

Please contact **Martha Jo Dendinger,** Managing Editor, at martha.dendinger@ahcmedia.com or (404) 262-5514.

then there is no master-servant relationship and the hospital is not directly liable for the emergency physicians' actions in the ED under state tort laws. (Though hospitals may be directly liable for the physicians under federal law, EMTALA, or vicariously liable under state law via various theories, such as *apparent authority* or *ostensible agency*.)

Also, analogous to this case, if an emergency physician who is employed by the hospital is treating neighbors or moonlighting at the corner urgent care center, then the hospital is not liable for the physician's negligence (and importantly, the malpractice insurance provided by the hospital typically does not cover the physician's practice away from the hospital).

Note also that the result in this case could be otherwise in different jurisdictions, either because of public policy considerations, adoption of the complete Restatement, or legislative action. For example, in Oregon the court in *Faverty v McDonald's Restaurants, Inc.*,[9] held the fast-food chain liable to a third party because it was reasonably foreseeable that employees scheduled to work excessive hours would fall asleep behind the wheel of a car when driving home and injure the third party. Also, in the Texas case of *D. Houston, Inc. v Love,*[10] a nightclub was held liable for the injuries sustained in a car accident by one of its dancers (an independent contractor), who became intoxicated due to a 'job requirement' that she consume alcohol, and the intoxication was the proximate cause of the accident. An intern's 'job requirement' that they stay up all night and become 'sleep deprived' and the sleep deprivation being the proximate cause of an auto accident is essentially the same thing. Studies have shown that sleep deprivation results in physical effects on coordination and judgment very similar to that experienced with alcohol intoxication.[11]

Plaintiff wanted the court to carve out a new exception to the general rules limiting liability to third parties, which would hold hospitals liable to third parties for the conduct of resident physicians who are required to work excessive hours.

However, since the plaintiff could not establish the special relationship involving the intern outside of the hospital required by the Restatement of Torts sections adopted by the Illinois Supreme Court, the court held that the hospital had no duty to control the conduct of the intern while she was driving home.[1]

Illinois Hospital Licensing Act

Lastly, Brewster argued that the hospital violated section 6.14 of the Hospital Licensing Act[3] and therefore, she should be able to sue the hospital for the damages she suffered as a result of the hospital's violation. Section 6.14 reads:

> *"Resident and intern duty hour requirements. Hospitals licensed under this Act shall comply with the duty hour requirements for residents and interns established by the Accreditation Council for Graduate Medical Education (ACGME)."*[3]

ACGME's duty hour standards mandate a 24-hour limit on continuous duty, with up to 6 added hours to participate in didactic activities, transfer care of patients, conduct outpatient clinics, and maintain continuity for continuity of care; a maximum of 30 consecutive hours.[4]

Based on the facts alleged by Brewster, the hospital had indeed violated the ACGME standards and thus the Illinois Hospital Licensing Act. However, the hospital maintained that section 6.14 of the Hospital Licensing Act did not grant plaintiff a private cause of action and therefore is not a ground for liability against the hospital.

Unfortunately for Brewster, the language of the Licensing Act does not expressly allow a plaintiff the right to seek damages for a hospital's violation of section 6.14. Still, the court said that a private right of action could be implied where: "(1) the plaintiff is a member of the class for whose benefit the statute was enacted; (2) the plaintiff's injury is one the statute was designed to prevent; (3) a private right of action is consistent with the underlying purpose of the statute; and (4) implying a private right of action is necessary to provide an adequate remedy for violations of the statute."[12]

Brewster's hope was short-lived, since the court decided that the Licensing Act was enacted to combat problems associated with *patient care*. Because Brewster was not a patient, the court saw no reason to conclude she had a private right of action against the hospital under section 6.14.[1]

Final ruling of the court

The court held that the hospital did not have duty under current Illinois law to control the weary intern's actions when she was off-duty, affirming the trial court's dismissal of Ms. Brewster's complaint.[1] Teaching hospitals everywhere breathed a huge collective sigh of relief.

Additional comments

Illinois may be the only state to specifically compel hospitals by statute to comply with the resident physician duty hour requirements of the ACGME.[3] However, it is not the only state to address the issue of the long hours worked by hospital interns and residents.[13]

Most notable is New York, which as a result of the famous Libby Zion case enacted its own resident duty hour standards in 1989 by revising the New York State Health Code.[14]

Eighteen-year-old Libby Zion was admitted to New York Hospital emergency department late at night with fever, flu symptoms, and intermittent agitation; she died less than eight hours later. Her father, Sidney Zion, an attorney, a writer for the *New York Times*, and former federal prosecutor launched a crusade against the hospital and the medical profession, claiming Libby's death was a direct result of errors made by a sleep-deprived intern and resident and total lack of supervision by the attending physician. (The cause of Ms. Zion's death was not definitively established, though it was most likely from a lethal combination of a monoamine oxidase inhibitor (Nardil), which Zion had been taking and hid from her doctors, and Demerol, which she was given in the hospital.)[14,15]

A Manhattan grand jury investigation rejected Sidney Zion's well publicized charges of medical "murder" and did not indict the doctors involved. It did, though, fine the hospital $13,000 for providing inadequate care and supervision in Libby's case, and stated that the physicians' excessive hours on duty contributed to the teenager's death.[16]

The family filed a lawsuit against the hospital that dragged on for more than a decade. Ultimately, the jury found Libby 50 percent liable for her own death for not telling the doctors she had taken cocaine and numerous prescription drugs (including Nardil) before they prescribed Demorol for her; it awarded the Zions $375,000.[14,15,17]

Various state medical licensing agencies and professional review boards conducted more than 30 investigative hearings, and the case prompted the New York state health commissioner to form a committee that recommended major changes in the delivery of emergency care, limited the consecutive hours that doctors in training can work, and required greater supervision by attending physicians.[16,18-20] The 1989 New York State Health Code changes were a direct result of the Zion case and the committee's recommendations.[19-21]

Subsequently, and also instigated and influenced by the Libby Zion case, the Residency Review Committee for Internal Medicine and the Accreditation Council for Graduate Medical Education set national restrictions on work hours similar to those of the NY Health Code for our nations 7,800 residency programs, which became effective in July 2003.[4,22] ■

References and Additional Resources

1. *Brewster v. Rush-Presbyterian-St. Luke's Medical Center,* N.E.2d 635 (Ill. App. Ct. 1st Dist., 2005); leave to appeal to Illinois Supreme Court denied, 844 N.E.2d 964 (Ill. 2006).
2. Restatement (Second) of Torts Sections 315 through 319 (1965).
3. Illinois Hospital Licensing Act, Section 6.14 (210 ILCS 85/6.14 (West 1996)).
4. Accreditation Council for Graduate Medical Education (ACGME) Duty Hour Requirement for Residency Programs. ACGME is responsible for evaluating and accrediting more than 7,700 accredited residency education programs in 110 medical specialties and subspecialties. The Council establishes and updates educational standards for residency programs. http://www.acgme.org/acWebsite/dutyHours/dh_Lang703.pdf See also, Accreditation Council for Graduate Medical Education, Report of the Work Group on Resident Duty Hours and the Learning Environment, June 11, 2002; (http://www.acgme.org).
5. See for example, Steele MT, Ma OJ, Watson WA, Thomas HA Jr, Muelleman RL. The occupational risk of motor vehicle collisions for emergency medicine residents. *Acad Emerg Med* 1999 Oct;6(10):1050-3; McCall TB. The impact of long working hours on resident physicians. *N Engl J Med* 1988;318(12):775-8; Davydov L, Caliendo G, Mehl B, Smith. LB. Investigation of Correlation Between House-Staff Work Hours and Prescribing Errors. *Am J Health-Syst Pharm* 61(11):1130-1134, 2004; Ayas NT, Barger LK, Cade BE, et al. Extended Work Duration and the Risk of Self-reported Percutaneous Injuries in Interns. *JAMA* 2006;296:1055-1062. National Study of Medical Interns Finds Eighty Four Percent Exceed ACGME Work Hour Limits; Link Made Between Needle Stick Injuries and Long Shifts. See September 6, 2006 http://www.ahrq.gov/news/press/pr2006/needlestpr.htm.
6. *Brewster v. Rush-Presbyterian-St. Luke's Medical Center*, N.E.2d 635 (Ill. App. Ct. 1st Dist., 2005), citing *City of Chicago v. Beretta U.S.A. Corp*., 821 N.E.2d. 1099 (Ill. 2004).
7. See, e.g., *Kirk v. Michael Reese Hospital & Medical Center*, 513 N.E.2d 387 (Ill. 1987); *Estate of Johnson v. Condell Mem. Hospital*, 520 N.E.2d 37, Ill. (1988); *Doe v. McKay*, 700 N.E.2d 1018, 233 Ill. (1998).
8. Restatement (Second) of Torts, Section 321 (1965).
9. *Faverty v. McDonald's Restaurants of Oregon, Inc.*, 892 P.2d 703 (1995).
10. *D. Houston, Inc. v. Love*, 92 S.W.3d 450 (Tex. 2002).
11. Veasey S, Rosen R, Barzansky B, Rosen I, Owens J. Sleep Loss and Fatigue in Residency Training: A Reappraisal. *JAMA* 2002;288:1116-24; Weinger MB, Ancoli-Israel S. Sleep Deprivation and Clinical Performance. *JAMA* 2002;287:955-57; Leung L, Becker CE. Sleep deprivation and house staff performance. Update 1984-1991. *J Occup Med* 1992; 34:1153-60.
12. *Brewster v. Rush-Presbyterian-St. Luke's Medical Center*, citing *Fisher v. Lexington Health Care, Inc*.,722 N.E.2d 1115, Ill. (1999).
13. Evans L. Regulatory and legislative attempts at limiting medical resident work hours. *J Legal Med*. 2002; 23:251-67; Whetsell JF. Changing the law, changing the culture: rethinking the "sleepy resident" problem. *Ann Health Law* 2003; 12(1):23-73.
14. Asch DA, Parker RM. The Libby Zion case. One step forward or two steps backward? *N Engl J Med* 1988; 318:771-5; See also, The Libby Zion Case. *Ann Intern Med* 1991 Dec 15;115(12):985-6; AJ Block. Revisiting the Libby Zion case. Editorial. *Chest* 1994;105(4):977-978.
15. Wallis C. Re-examining the 36-hour day. New York State leads a movement to change the way U.S. doctors are trained. *Time* 1987 Aug 31;130(9):54-5; Robins N. *The Girl Who Died Twice; Every Patient's Nightmare: The Libby Zion Case and the Hidden Hazards of Hospitals*. 350 pp. New York. Delacorte Press.
16. Spritz N. Oversight of physicians' conduct by state licensing agencies. Lessons from New York's Libby Zion case. *Ann Intern Med* 1991 Aug 1;115(3):219-22.

17. *Zion v. New York Hosp*., 183 A.D.2d 386 (N.Y. App. Div. 1992).
18. Holzman IR, Barnett SH. The Bell Commission [NY State Commission convened after the Libby Zion case]: Ethical implications for the training of physicians. *Mt Sinai J Med* 2000;56:136-139.
19. Brensilver JM, Smith L, Lyttle CS. Impact of the Libby Zion case on graduate medical education in internal medicine. *Mt Sinai J Med* 1998 Sep;65(4):296-300.
20. Reiner SC. The impact of the new code regulations on post-graduate medical education in New York State. *N Y State J Med* 1989 Aug;89(8):457-61.
21. Kelly A, Marks F, Westhoff C, Rosen M. The effect of the New York State restrictions on resident work hours. *Obstetr Gynecol* 1991 Sep;78(3 Pt 1):468-473; Laine A, Goldman L, Soukup JR, Hayes JG. The impact of a regulation restricting medical house staff working hours on the quality of patient care. *JAMA* 1993;269:374-378.
22. Ludmerer Km, Johns MM. Reforming graduate medical education. *JAMA* 2005;294:1083-87.

Does ED ultrasound really increase risk of a lawsuit?

In fact, the opposite is true, say experts

By Staci Kusterbeck, Contributing Editor

With an increasing number of emergency department (ED) physicians using ultrasound, are malpractice lawsuits also on the rise? Quite the contrary, according to proponents of ED ultrasound. "As long as we are observing proper credentialing and training guidelines, we are actually decreasing our risk—considerably so," says **Michael Blaivas**, MD, RDMS, immediate past chair for the American College of Emergency Physicians (ACEP)'s ultrasound section and chief of the section of emergency ultrasound in the department of emergency medicine at Medical College of Georgia in Augusta.

Key Points

Malpractice lawsuits involving use of ultrasound in the emergency department have not increased. In fact, lawsuits could occur if ultrasound is not used and treatment is delayed as a result.

- Physicians should not make clinical decisions based on ultrasound scans until national standards for credentialing are reached.
- Tell patients that you are doing a focused examination and looking only for emergent conditions.
- ED ultrasound can save lives by identifying abdominal aortic aneurysms and ectopic pregnancies earlier.

The major legal pitfall of ED physicians doing ultrasound is that, in some cases, they may not have received the proper training or hospital credentialing, adds Blaivas. "Most problems such as misses occur in the hands of novice emergency sonologists who are not ready to make decisions from their scans," he says.

So when can ED physicians begin making clinical decisions based on ultrasound scans? At a moderate level of experience, but no one should make clinical decisions based on their ultrasound examinations if they are not credentialed to do so by the hospital, says Blaivas. "If this sounds vague, it is because many hospitals have different credentialing criteria for emergency ultrasound," he says. Currently, the only specialty-wide guidelines for training and credentialing are those that were created by ACEP. (*To access the guidelines, go to www.acep.org. Under "Practice Resources," click on "Issues by Category," "Ultrasound," "Emergency Ultrasound Guidelines."*)

However, Blaivas cautions that if the hospital in question has very loose criteria that do not meet national standards, then the physician should voluntarily refrain from making decisions until she or he has reached national standards for credentialing.

"In the past the greatest mistake of emergency physicians was assuming that a one, two or three-day training course made you capable of making decisions from your ultrasound examinations," Blaivas says. "This is not the case. The initial course is just a starting point for more learning and a progression to credentialing."

Technical expertise, a quality control system, credentialing, and working closely with radiology are all incumbent on physicians who use ultrasound, says **Corey M. Slovis,** MD, chairman of the department of emergency medicine at Vanderbilt University Medical Center in Nashville, TN. "This is a time when what being credentialed means is very unclear," he says. "In the current environment, ED physicians need to follow closely any formal recommendation, from ACEP, AAEM [the American Academy of Emergency Medicine], or emergency ultrasound organizations."

The most likely scenario for an ED physician to be sued? When a decision is made to send the patient home based on an inappropriately interpreted ultrasound, which delays surgical intervention on a serious issue resulting in a bad outcome, says **Bruce David Janiak**, MD, vice chair of the department of emergency medicine at Medical College of Georgia. "For the most part, the major pitfalls are doing ultrasound without the proper background and training," he says. "Otherwise it's a major benefit rather than a setback."

—continued on page 128

SPECIAL REPORT

Emergency Physician Contracts: Terms to Ponder, Part II

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

In the September issue of ED Legal Letter, two common contract clauses – malpractice insurance and restrictive covenants— that can be harmful to the interests of an emergency physician. This issue focuses on indemnification clauses, "for cause" termination clauses, and integration clauses.

Indemnification Clauses

Indemnification or "hold harmless" clauses are dangerous additions to any contract. When you think of indemnification, think of an insurance policy – which is another company indemnifying you for your losses. Motor vehicle insurance reimburses an insured for any losses related to driving a motor vehicle (that are not excluded in the policy and are not above the policy limits). If a physician agrees to an indemnification clause in a contract, the physician is promising to reimburse the other party for any losses related to the contract terms.

In *Chehval v. St. John's Mercy Medical Center*, a medical center entered into a contract with a physician and agreed to "indemnify and hold harmless" the physician for "all sums . . . arising out of the rendering of or failure to render professional services . . . described in [the contract]."[1] When the physician was sued in a wrongful death action, the medical center refused to pay, alleging that the physician should have purchased medical malpractice insurance to cover him for such events. The physician then filed a lawsuit to force the medical center to defend him. The trial and appellate courts both agreed that the wrongful death lawsuit "arose out of" the physician rendering professional services under the contract. Because the medical center agreed to indemnify the physician, it was required to pay for all costs of the wrongful death lawsuit, including attorney's fees and any judgments against the physician.

When indemnification clauses are broadly worded, they can result in unexpected legal liability. For example, in *Records v. Aetna Life & Casualty Insurance*, an insurance company was forced to pay for a judgment against a physician who physically assaulted a nurse.[2] In this case, the physician became angry because a nurse transferred his patient from a nursing home without his permission. The physician grabbed the nurse by the arm, led her into another room, shouted at her, and pointed his finger in her face. While the nurse was backing away from the physician, she fell over a table, injuring her back. In a subsequent lawsuit to enforce coverage, both courts believed that the altercation between nurse and physician would not have taken place absent the physician providing professional services to patients in the nursing home. The assault and battery therefore, "arose out of" professional services the physician was providing to the patient. The insurance company was required to defend the assault and battery action against the physician and could be held responsible for paying any judgment against the physician on the assault and battery claim.

A physician who agrees to an indemnification clause relating to provision of medical services may be responsible for paying a hospital for lost profits, malpractice settlements, attorney's fees, costs in recruiting new physicians, and other tangential costs. With few exceptions, indemnification clauses in contracts should be deal-breakers. Most contracts don't have indemnification clauses, and the benefits in any contract containing an indemnification clause will not justify the substantial added legal risk. If the other party will not delete or substantially limit an indemnification clause, find another contract.

Termination Clauses

While it may seem odd to consider your exit strategy before you even sign a contract, most physicians will eventually decide to leave their job. In the absence of a contract, employment positions are generally terminable "at will." If a contract is present, the terms of the agreement govern the circumstances under which either party may terminate the contract.

Termination clauses either occur *without cause* or *for cause*. Parties may terminate a contract without cause either unilaterally or by agreement. A mutual agreement to terminate a contract may take place at any time – the parties just have to agree to the terms. A decision to unilaterally terminate a contract without cause requires a notice period, which can be as short as 30 days or long as 180 days (or more), but is typically 60 to 90 days.

This notice period gives the physician time to obtain staff privileges at another hospital and gives the hospital time to find another physician.

Physicians may find their stream of income jeopardized when hospitals or contract groups invoke for cause termination clauses. Many contracts contain unilateral clauses allowing the physician to be immediately terminated under certain circumstances. Some for cause clauses make sense. For example, allowing the physician to be immediately terminated if the physician's medical license is revoked or if the physician dies. Other clauses may be very vague, essentially allowing the physician to be terminated for any reason. For example, a contract may contain language that allows the physician to be terminated for cause if the physician does not meet "anticipated patient volumes" or if hospital staff "requests that the physician be removed from the schedule." The problem with immediate for cause terminations is that before the physician can begin earning a salary at another hospital, the physician has to find an opening and then obtain staff privileges. With credentialing committees sometimes meeting only every three months, a physician may have no income for several months.

In *Miranda v. Wesley Health System*, an emergency physician signed an employment contract containing 14 provisions under which the hospital could immediately terminate the physician "for cause."[3] Many of these provisions were vague, including a violation of the hospital's "rules, policies, and/or procedures," failing to meet "utilization performance efficiency," and behavior deemed "unethical, unprofessional, fraudulent, unlawful, or adverse to the interest, reputation or business of Hospital." The contract made the hospital the sole judge of when these provisions would apply.

When the physician reported to the hospital for work one day, he was called into the hospital CEO's office and fired for multiple complaints alleging "rude and obnoxious" behavior toward patients. The physician then brought a lawsuit against the hospital for wrongful termination, stating that the real reasons for his termination were his refusal to overprescribe antibiotics and refusal to prescribe narcotics to drug-seekers. The trial court dismissed the physician's lawsuit against the hospital, and the appellate court agreed, stating that the terms of the contract made the physician an at-will employee. The vague for cause termination provisions cited above allowed the hospital to terminate the physician for any reason or for no reason at all.

Protecting oneself from for cause terminations can be difficult. One thing that will help is to have staff privileges at more than one hospital. Doing so will prevent the delay in obtaining other hospital privileges if you are fired. Removing the vague for cause provisions or modifying them so that they are made in good faith also can lessen the physician's risk. Finally, requiring an employer to notify the physician of any events that may cause the termination clauses to be invoked may give the physician a "heads up" that he/she needs to start looking for another job. As with indemnification clauses, if a hospital will not remove or significantly change vague for cause provisions, strongly consider looking for a different position.

Integration Clauses

These clauses usually contain language to the effect that the contract "constitutes the entire agreement of the parties" and that no other agreements or understandings are enforceable. While seemingly innocuous, integration clauses can result in a situation similar to a 'bait and switch.' If a group offers to pay you a $25/hour weekend shift differential on your interview, but this differential is not expressly stated in your contract, an integration clause might prevent you from receiving this differential. Similarly, an integration clause might prevent you from receiving the paid vacation you were verbally promised, but that did not show up in the explicit language of the contract.

Get all verbal promises in writing before you sign a contract. If you are offered a contract that does not contain terms you verbally agreed upon, write the terms in the margin and have the other party initial them. ■

References

1. *Chehval v. St. John's Mercy Medical Center*, 958 S.W.2d 36 (1997).
2. *Records v. Aetna Life & Casualty Insurance,* 683 A.2d 834 (1996).
3. *Miranda v. Wesley Health System*, 2005-CA-00925-COA (Miss. 2006).

continued from page 125

Focused exam is key

One potential problem is failing to keep proper focus to the examinations done in the ED. "For instance, when I scan an elderly patient with abdominal pain that is radiating to the back to rule out an AAA [abdominal aortic aneurysm] I am not scanning the entire abdomen for all problems—I have a very focused goal," says Blaivas. "I am not pretending I can diagnose a mass in the tail of the pancreas."

The same is true for scans of the gallbladder, kidneys, heart, pelvis, and for deep venous thrombosis (DVT). Be clear with patients that this is a focused examination to answer a specific question, advises Blaivas, such as: Is there an AAA? Is there an intrauterine pregnancy? Is there a pericardial effusion? or Is there a DVT?

"If you have done an echo [echocardiogram] for pericardial effusion, say there isn't one, and the patient dies of tamponade, that's a problem," says **Christopher L. Moore**, MD, RDMS, FACEP, assistant professor for the section of emergency medicine at Yale University School of Medicine.

That may be fairly obvious, but many ED physicians are worried about missing things they *shouldn't* necessarily be expected to find. "People worry about that, specifically missing a malignancy on an image, but I would hope it would hold up in court that we are not looking for those things when we are doing focused ultrasound," says Moore. "We aren't looking for a liver malignancy or other things that are not emergent complaints. We are looking for things that need to be intervened on right now."

Moore recommends using a preprinted template or language stating, "This is a limited focused ultrasound and is not meant to replace a comprehensive ultrasound done by a radiologist or cardiologist."

No increase in lawsuits

Despite its growing use, there has been no apparent surge in malpractice allegations involving ultrasound in the ED. "Of 850 cases I've reviewed in 30 years, I've only had one that involved misinterpretation of ultrasound by an emergency physician," says Janiak. "I don't see an increase at all."

In fact, the lack of litigation involving ED ultrasound is somewhat surprising, says Blaivas. "Radiologists get sued all of the time for missing things on ultrasound, CT, MRI, and X-rays," he says. "We are all fallible, and especially when proper training, protocol, or technique is absent, things will be missed."

There is actually a growing potential for lawsuits as a result of an ED physician *not* doing an ultrasound exam, says Blaivas. For example, some attorneys are seeking out patients who were injured during the placement of a central line.

"If ultrasound was not used, you have a lawsuit for negligence," says Blaivas. "Why? Because it is recommended by multiple societies and studies, and is known to reduce risk of injury when used in real time to place a central line. Thus, a physician will have to answer why they are behind the times." In fact, ED ultrasound may be approaching the standard of care, says Moore, referring to a recommendation by the Agency for Healthcare Research and Quality for real-time ultrasound guidance during central line insertion to prevent complications.[1] "With that report in mind, if ultrasound is available in your ED and you don't use it while placing a central line, and then puncture a lung or lacerate an artery, it is conceivable that you could be held liable for that," says Moore.

The fact remains that ultrasound does have the potential to increase the risk of being sued with an adverse judgment if the physician makes a care decision based on a faulty read, or reads at a higher level than his competency, says Slovis. "That image can be used to find fault and a judgment against the physician," he says. "Telling a patient that it's gastritis when ultrasound reveals an AAA that [later] ruptures, carries more risk than if you referred that patient for imaging by a ultrasonographer based in radiography."

On the other hand, ultrasound also has great potential to pick up emergency conditions immediately, allowing patients to be operated on more accurately and faster. "If you're using the technology, you better know what you are doing. But certainly picking up an ectopic pregnancy, which are occasionally discharged, would decrease risk," says Slovis.

Similarly, attorneys may ask why the ED physician failed to discover a patient's AAA as soon as the patient came in, instead of hours later after the patient was admitted. "I actually think this is the next frontier of emergency ultrasound-related litigation," says Blaivas. "If it is part of training, recommended and practiced by so many, why did you not use it to save my client's husband/wife/daughter/son?"

For example, a lawsuit could be filed if an ultrasound exam was delayed or not given for a hypotensive patient with vaginal bleeding. "Even if the quantitative BHCG is low or you are still waiting for one, that scan should occur immediately and will make a difference," he says. "I think we will see fewer 'missed this one' lawsuits than we have feared. And while these will occur, they will not be any more frequent than what our radiology colleagues suffer per 1000 patients seen."

ED physicians are generally cautious about ultrasound, and leaders in the field stress proper training, credentialing, and focused applications that do not stretch the capabilities of the clinician, adds Blaivas.

Blaivas points to one radiologist's declaration that he would hire himself out to anyone who is planning a suit against an emergency physician using ultrasound. "There will be a push by mean-spirited people like that, I am sure," he says. However, in most states it will have to be another emergency physician who gives an opinion if it was reasonable for something to be missed or an ultrasound not performed, he adds.

"If we do more things, we do increase our risks," acknowledges Janiak. "However, that is offset by getting the patient cared for faster and finding out some things that are extremely urgent and getting the correct specialist in to take care of the problem."

In some cases physicians have been sued for missed diagnoses that they might have caught if they had used ultrasound, says Moore. He points to a lawsuit involving a patient who died because nobody knew the patient had a pericardial effusion. "This was before we had ultrasound in the ED. It's hard to get an echo [echocardiogram] in the middle of the night. My feeling is that if they had ultrasound they would not have missed it," he says.

On one occasion, ED physicians at Piedmont Fayette Hospital in Fayetteville, GA used ultrasound to determine that a patient's abdomen was filled with blood. "Fortunately the OB respected my interpretation and came in immediately. This might have saved the patient's life because she was in shock from an ectopic pregnancy," says Janiak. "Had we followed the normal procedure, I think that patient probably would have died in the ED." ■

Reference

1. Shojania KG, Duncan BW, McDonald KM, et al. *Making Health Care Safer: A Critical Analysis of Patient Safety Practices. Evidence Report/Technology Assessment Number 43.* AHRQ Publication 01-E058. Rockville, MD: Agency for Healthcare Quality and Research. July 2001.

What one ED physician missed on an ultrasound

By Staci Kusterbeck, Contributing Editor

The following ultrasound image of of a patient who had been shot in the chest and was not doing well. The physician thought the patient's lung was collapsed, and he put in a chest tube. He then performed an ultrasound of the heart and saw no pericardial effusion and noted that the heart was beating.

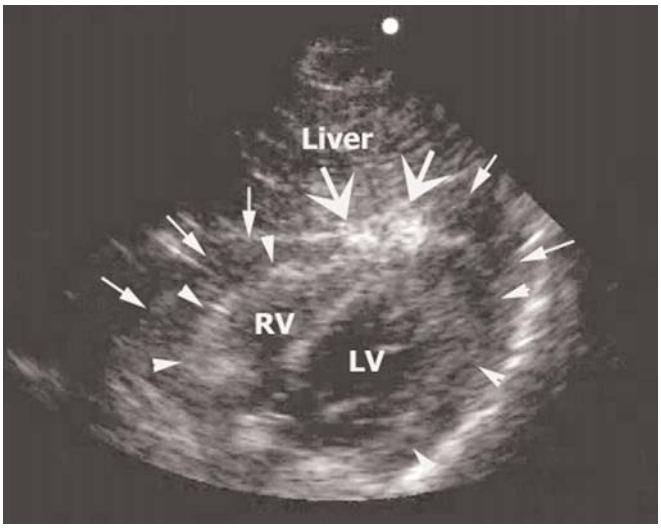

Image courtesy of Michael Blaivas, MD, RDMS, Medical College of Georgia, Augusta.

"He [the physician] had never taken an ultrasound course and learned a bit here and there on his own," says **Michael Blaivas**, MD, RDMS, chief of the section of emergency ultrasound in the department of emergency medicine at Medical College of Georgia in Augusta. "He was not credentialed for ultrasound in any way by the hospital as he had never really been that interested in it."

The patient only got worse, but the heart was not involved. The patient was given fluids and blood through central lines but lost his pressure despite this. The ultrasound image shows a mistake that was potentially fatal to this patient.

The ultrasound image is from the subxiphoid position, part of the FAST examination. The liver is labeled and on top of the image. The left ventricle (LV) is seen and so is the right ventricle (RV). "The two atria are not clear in this shot but were seen well in others," explains Blaivas. The long thin arrows point to what was thought to be the outer border of the heart, the outer pericardial layer. The arrow heads point to the actual outer outline of the heart. What is in between? A pericardial effusion that has clotted and looks bright and was confused with being part of the myocardium.

The large arrows point to a bright spot at the apex of the heart. It is not normally seen there. This is where the bullet actually hit. It did not penetrate the heart, but only caused a bruise that led to bleeding into the pericardial sac.

All of this was confirmed at autopsy. If the scan had been interpreted correctly, it would have led to an immediate thorocotomy and cutting of the pericardial sac, which would have revealed tamponade.

"This is Monday morning quarterbacking but is a valid point," says Blaivas. "Had this physician

obtained proper training at a course, practiced these scans enough to be credentialed by the hospital, and kept up his skills as with anything in emergency medicine, he would have known to look more carefully, use additional views and [would have] caught the effusion." ■

New legislation protects ED staff who ID unsafe care

Law ensures discussions about safety won't "show up in a courtroom"

By Staci Kusterbeck, Contributing Editor

The Patient Safety and Quality Improvement Act of 2005 provides full privilege for information shared with a patient safety organization, with the goal of encouraging voluntary error reporting. How will the new legislation affect EDs and malpractice cases?

"As usual in the law, the answer is: 'it depends,'" says **Bryan A. Liang**, MD, PhD, JD, executive director of the Institute of Health Law Studies at California Western School of Law in San Diego, CA and co-director and adjunct associate professor of anesthesiology at University of California—San Diego School of Medicine.

Original patient care information, such as the medical charts, won't be protected from discovery under the law. However, any analysis or discussion of improving system safety and quality by those involved, as well as any transfer of that information beyond the ED entity, will not be discoverable if the hospital fulfills the requirements of the law by working with one or more Patient Safety Organizations (PSOs).

"This is of great advantage to emergency departments, which are high intensity clinical settings where errors and system weaknesses can result in significant patient harm," says Liang. "It allows for sharing of experiences and data to improve system safety and quality, without fear of having these discussions show up in a courtroom."

On the one hand, reporting errors may subject ED staff to liability suits just as any patient injury might, says Liang. However, reporting errors that lead to system improvements may ultimately benefit EDs, since unsafe practices will be identified.

Reporting information that already is documented in the patient's chart won't increase or decrease ED provider liability. "If the patient is going to sue, the chart has all the relevant information and will be accessible to the patient's attorney," says Liang. "Ethically, of course, we should always report errors if safety and quality will be improved."

This idea is at the heart of the patient safety legisla-

United States Postal Service
Statement of Ownership, Management, and Circulation

1. Publication Title	2. Publication No.	3. Filing Date
ED Legal Letter	1 0 8 7 - 7 3 4 1	10/01/06
4. Issue Frequency	5. Number of Issues Published Annually	6. Annual Subscription Price
Monthly	12	$499.00

7. Complete Mailing Address of Known Office of Publication *(Not Printer) (Street, city, county, state, and ZIP+4)*
3525 Piedmont Road, Bldg. 6, Ste. 400, Atlanta, Fulton County, GA 30305
Contact Person: Robin Salet
Telephone: 404/262-5489

8. Complete Mailing Address of Headquarters or General Business Office of Publisher *(Not Printer)*
3525 Piedmont Road, Bldg. 6, Ste. 400, Atlanta, GA 30305

9. Full Names and Complete Mailing Addresses of Publisher, Editor, and Managing Editor *(Do Not Leave Blank)*
Publisher *(Name and Complete Mailing Address)*
Brenda Mooney, 3525 Piedmont Road, Bldg. 6, Ste. 400, Atlanta, GA 30305
Editor *(Name and Complete Mailing Address)*
Martha Dendinger, same as above
Managing Editor *(Name and Complete Mailing Address)*
Glen Harris, same as above

10. Owner *(Do not leave blank. If the publication is owned by a corporation, give the name and address of the corporation immediately followed by the names and addresses of all stockholders owning or holding 1 percent or more of the total amount of stock. If not owned by a corporation, give the names and addresses of the individual owners. If owned by a partnership or other unincorporated firm, give its name and address as well as those of each individual. If the publication is published by a nonprofit organization, give its name and address.)*

Full Name	Complete Mailing Address
AHC Media LLC	3525 Piedmont Road, Bldg. 6, Ste 400
	Atlanta, GA 30305

11. Known Bondholders, Mortgagees, and Other Security Holders Owning or Holding 1 Percent or More of Total Amount of Bonds, Mortgages, or Other Securities. If none, check box → ☐ None

Full Name	Complete Mailing Address
Thompson Publishing Group Inc.	1725 K Street NW, Suite 700
	Washington, D.C. 20006

12. Tax Status *(For completion by nonprofit organizations authorized to mail at nonprofit rates.) (Check one)*
The purpose, function, and nonprofit status of this organization and the exempt status for federal income tax purposes:
☐ Has Not Changed During Preceding 12 Months
☐ Has Changed During Preceding 12 Months *(Publisher must submit explanation of change with this statement)*

PS Form **3526**, September 1998 *See instructions on Reverse)*

13. Publication Name	14. Issue Date for Circulation Data Below
ED Legal Letter	September 2006

15. Extent and Nature of Circulation			Average No. of Copies Each Issue During Preceding 12 Months	Actual No. Copies of Single Issue Published Nearest to Filing Date
a. Total No. Copies *(Net Press Run)*			526	500
b. Paid and/or Requested Circulation	(1)	Paid/Requested Outside-County Mail Subscriptions Stated on Form 3541. *(Include advertiser's proof and exchange copies)*	273	250
	(2)	Paid In-County Subscriptions *(Include advertiser's proof and exchange copies)*	3	3
	(3)	Sales Through Dealers and Carriers, Street Vendors, Counter Sales, and Other Non-USPS Paid Distribution	7	5
	(4)	Other Classes Mailed Through the USPS	13	7
c. Total Paid and/or Requested Circulation *(Sum of 15b(1) and 15b(2)*			296	265
d. Free Distribution by Mail *(Samples, Complimentary and Other Free)*	(1)	Outside-County as Stated on Form 3541	18	17
	(2)	In-County as Stated on Form 3541	0	0
	(3)	Other Classes Mailed Through the USPS	0	0
e. Free Distribution Outside the Mail *(Carriers or Other Means)*			35	45
f. Total Free Distribution *(Sum of 15d and 15e)*			53	62
g. Total Distribution *(Sum of 15c and 15f)*			349	327
h. Copies Not Distributed			177	173
i. Total *(Sum of 15g, and h.*			526	500
Percent Paid and/or Requested Circulation *(15c divided by 15g times 100)*			85	81

16. Publication of Statement of Ownership
Publication required. Will be printed in the November 2006 issue of this publication. ☐ Publication not required.

17. Signature and Title of Editor, Publisher, Business Manager, or Owner: Brenda S. Mooney, Publisher — Date: 9/20/06

I certify that all information furnished on this form is true and complete. I understand that anyone who furnishes false or misleading information on this form or who omits material or information requested on the form may be subject to criminal sanctions (including fines and imprisonment) and/or civil sanctions (including multiple damages and civil penalties).

Instructions to Publishers

1. Complete and file one copy of this form with your postmaster annually on or before October 1. Keep a copy of the completed form for your records.
2. In cases where the stockholder or security holder is a trustee, include in items 10 and 11 the name of the person or corporation for whom the trustee is acting. Also include the names and addresses of individuals who are stockholders who own or hold 1 percent or more of the total amount of bonds, mortgages, or other securities of the publishing corporation. In item 11, if none, check the box. Use blank sheets if more space is required.
3. Be sure to furnish all circulation information called for in item 15. Free circulation must be shown in items 15d, e, and f.
4. Item 15h., Copies not Distributed, must include (1) newsstand copies originally stated on Form 3541, and returned to the publisher, (2) estimated returns from news agents, and (3), copies for office use, leftovers, spoiled, and all other copies not distributed.
5. If the publication had Periodicals authorization as a general or requester publication, this Statement of Ownership, Management, and Circulation must be published; it must be printed in any issue in October or if the publication is not published during October, the first issue printed after October.
5. In item 16, indicate date of the issue in which this Statement of Ownership will be published.
6. Item 17 must be signed.

Failure to file or publish a statement of ownership may lead to suspension of second-class authorization.

PS Form **3526**, September 1999 *(Reverse)*

tion, which recognizes that many in the health care field want to do the right thing and talk about errors to give safer care to their patients, says Liang.

"But with a legal system that is expensive, not very accurate in determining poor care versus bad outcomes, and in an environment of distrust, it is inevitable that there were few reports," says Liang. "However, now with the protections set up by the act, ED staff should be looking toward a new infrastructure where care can be improved and their efforts won't be used against them."

Lessons can be shared

The legislation specifically covers reports to PSOs, but may include broader reporting as well, says Liang. The critical requirement is that the health care entity work with PSOs for the statutory protections to occur, however.

However, since the reports and analysis created by the entity for the PSO are considered "patient safety work product," these may be shared with other hospitals or organizations, with the protections of the law following the materials.

This is something that gives the law "teeth," since under uneven state peer review privilege, the protections were for the peer review committee discussions, and *not* for the materials, says Liang.

"If someone talked about the safety and quality analysis outside the peer review meeting, everything became discoverable," he says. "So no one could talk, and no one could share outside the meeting, including to the ED or hospital next door. Now, with the protections following the materials, sharing of lessons learned and information to everyone in the facility and in the world can occur to promote patient care while still being protected."

Because the law is federal, EDs will no longer need to rely on uneven state-based peer review protections for safety and quality improvement activities, says Liang. State peer review statutes have not been a good protector of safety information and analysis, and materials, such as root causes, analyses have been deemed discoverable.

If a malpractice suit is coupled with a federal claim and filed in a federal court, rather than state court where malpractice actions are usually filed, the state peer review protections don't apply—a fact that plaintiffs' attorneys are using to avoid state peer review laws.

"Hence, the new federal law will address that very important issue through its protections, and block end run efforts by plaintiff's attorneys—assuming that hospitals fulfill the terms of the statute by working with PSOs," Liang says.

Liang gives the following recommendations for EDs:

- Ensure that your ED sets up Patient Safety Evaluation Systems (PSESs) to discuss and analyze patient safety data on actual adverse events and near misses.
- Report errors and system weaknesses through this system, to ensure the maximum potential protec-

Key Points

Under the Patient Safety and Quality Improvement Act of 2005, discussions of quality and safety are protected from discovery, as long as the law's requirements are met.

- Patient care information, such as medical charts, will not be protected.
- Analysis about improving safety will no longer be discoverable.
- The law will make it easier for ED staff to share lessons learned about safety.

CNE/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. ■

CNE/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. ■

tions for the information. Discuss the data and analyses in official PSES meetings.
- Work with PSOs to assist in identifying, analyzing, and improving system delivery safety and quality. "It is very important to note that health care entities *must* work with PSOs to garner the broad protections of the new law," says Liang. "PSO requirements will be announced in forthcoming regulations."

As for liability issues when ED staff report an error internally, or to an external agency such as the Institute for Safe Medication Practices (ISMP), the answer is again "it depends," says Liang. "Reporting errors by itself doesn't create liability internally or externally," he says. "What it may do is support a lawsuit."

Internal reports that are discoverable can be used by plaintiff's lawyers to support their case—which is why creating and maintaining a PSES is so important, says Liang. "Original materials such as the patient's chart are always discoverable—so if the report just repeats what's in the chart, there's no protection," he says. "But if there is analysis within the report and it's intended to go to a PSO for quality and safety purposes, then protection arguably applies."

For external reports to organizations such as ISMP, the same analysis applies—if it's for quality and safety purposes, and part of the PSES working with a PSO, the protections go with the materials. "But if it just repeats what's in the chart, there's no protection," says Liang. ■

CNE/CME *Questions*

49. Which of the following scenarios could result in a potential lawsuit involving an ED physician's use of ultrasound?
    A. A patient's emergency condition is missed.
    B. An ultrasound exam is delayed, resulting in a bad outcome.
    C. Ultrasound is not used, and a patient is discharged with a pericardial effusion.
    D. All of the above.

50. Which of the following is recommended to reduce liability risks of ED ultrasound?
    A. Tell patients that the ED exam is comparable to a comprehensive ultrasound done by a radiologist.
    B. Use ultrasound only for patients who are going to be admitted.
    C. Inform patients that the exam is looking only for emergent medical conditions.
    D. Allow all ED physicians to make clinical decisions based on ultrasound after a one-day training class.

51. Which of the following is discoverable under the Patient Safety and Quality Improvement Act of 2005, if the law's requirements are met?
    A. Original patient care information such as medical charts
    B. Discussion of improving safety by staff involved in a sentinel event
    C. Analysis of quality by administrators not directly involved in patient care
    D. Discussion about unsafe practices that is transferred to another facility

52. A physician who agrees to an indemnification clause relating to provision of medical services may be responsible for paying a hospital for which of the following?
    A. Lost profits
    B. Costs in recruiting new physicians
    C. Malpractice settlements and attorney's fees
    D. All of the above

Answers: 49. D; 50.C; 51. A; 52. D