ED Legal Letter™

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IN THIS ISSUE

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Halting inappropriate expert witness testimony – Part I: Professional associations' efforts to police 'experts'

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

Introduction

Physicians believe that most medical malpractice lawsuits are without merit. Even President George Bush in his 2004 State of the Union address stated that Congress needed to "eliminate wasteful and frivolous medical lawsuits in order to protect the doctor-patient relationship and keep good doctors doing good work." In fact, between 60% and 80% of all medical malpractice claims filed against physicians end with absolutely no payment to the plaintiffs or their attorneys.[1] However, the litigation costs of time, grief, reputation, and money extracts a substantial toll on the profession. The legal costs alone to force dismissal of an obviously non-meritorious case run around $20,000.[1]

One of the factors leading to such a high frequency of frivolous claims is believed to be erroneous, egregious, unscrupulous, or outright false testimony provided by medical 'experts' opining on the standard of care provided by the physician defendants.

After 'winning' a case against such an expert, the physician who was sued is understandably upset and angry at the expert and would like some fashion of retribution. 'Countersuits' against the expert, primarily for defamation, have been almost universally unsuccessful. Defamation occurs when a false statement is made to a third party about another person that is damaging to that person's reputation or good name.[2] Certainly, false expert witness testimony against a physician in the public forum of a lawsuit would meet the legal definition of defamation.

Unfortunately (at least for physicians sued for malpractice), there exists an iron-clad legal privilege that immunizes experts from liability for statements made in depositions or at trial. Any comments made by the expert in the course of judicial proceedings that are relevant to the issues of the case are absolutely privileged, and this may surprise many physicians, even if those comments are known to be untrue or are outright malicious![3] The stated public policy behind this absolute privilege is the desire to protect the interests of injured parties by ensuring open access to the courts without the fear or burden of defamation suits and to preserve the integrity of the judicial system.[3]

However, if a physician makes defamatory comments against another physician outside the confines of the legal proceeding, where the judicial privilege does not apply, then that physician can be liable for defamation.[4] (See the Florida *Fullerton* case in next month's *ED Legal Letter*.)

A more viable method to seek redress against an unscrupulous expert and combat false or exaggerated expert witness testimony is through peer review actions via professional associations, or through state medical boards, which will be addressed in Part II next month. A recent case highlights the issues involved, the potential hurdles to such actions, and the underpinning logic of the courts.

Bundren v. Parriott[5]

Dr. Parriott, an obstetrician/gynecologist practicing in Salina, Kansas, settled a lawsuit filed against him for $10,000, denominated as "exclusively and expressly for the reimbursement of expenses incurred by attorneys for the plaintiffs . . ." [5] Dr. Bundren, a faculty member of the University of Oklahoma College of Medicine in Tulsa, was the plaintiff's expert who testified at deposition that Dr. Parriott failed to comply with the applicable standard of care in the case. Both physicians were members of the American College of Obstetricians and Gynecologists (ACOG), which has a grievance process available to review complaints of one member against another member for violation of the College's Code of Professional Ethics or "Expert Witness Affirmation" statement.[5,6] The affirmation statement, which Dr. Bundren signed in conjunction with Dr. Parriott's case, provides that the testifying witness will comply with the College's listed principles in providing expert witness testimony.[5]

Subsequent to settling the malpractice claim, Dr. Parriott filed a complaint with ACOG's grievance committee charging that Dr. Bundren materially misrepresented the facts in the case and failed to comply with the affirmation principles of:

> *"I will conduct a thorough, fair, and impartial review of the facts and the medical care provided, not excluding any relevant information."*
> *"I will provide evidence or testify only in matters in which I have relevant clinical experience and knowledge in the areas of medicine which are the subject of the proceeding."* [5,6]

In the complaint, Dr. Parriott noted that Dr. Bundren gave testimony based on an incomplete review of the facts available to him and gave testimony outside his area of clinical experience. In fact, at his deposition, Dr. Bundren admitted he did not read the complete deposition testimony of the plaintiffs prior to providing his expert opinion in that case, but instead just reviewed a few select passages of their testimony with the plaintiff's counsel just before his deposition. He also relied on a statement given by an outside party, without considering the statements of the parties, which contradicted his conclusions. Dr. Bundren also conceded in his deposition in that case that he had never had relevant clinical experience regarding one of the primary issues in the case (home childbirth) consultation about risk factors as they relate to a patient's candidacy for home birth, nor was he aware of any standards or protocols as they relate to the evaluation of a patient considering home delivery.[5]

In response to Dr. Parriott's complaint to ACOG, Dr. Bundren filed a lawsuit against Dr. Parriott seeking damages for defamation and tortuous interference with his medical-legal consulting business. Dr. Parriott, in turn, asked the court to grant summary judgment in his favor and against Dr. Bundren on the grounds that his ACOG claim contained no false or defamatory words.[5]

The court noted that Dr. Parriott's complaint contained an extended recitation of the underlying facts,

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followed by his opinions on how the facts demonstrate that Dr. Bundren violated the ACOG Ethics and Expert Witness principles. The court first ruled that under Kansas law "an opinion is not actionable where it discloses the facts upon which the opinion is based, regardless of whether the opinion is defamatory."[7]

Second, the court held that the allegations in the ACOG complaint were substantially true (and all based upon specific statements in Dr. Bundren's own testimony), and that truth or substantial truths are a complete defense to a claim of defamation.[8] Alternatively, the court found that Dr. Bundren's defamation claim should be dismissed because there was no evidence that the ACOG complaint was communicated with the intent of harming Dr. Bundren's reputation. Dr. Parriott utilized ACOG's confidential grievance procedure and did not communicate any allegation against Dr. Bundren to a third party.[5] In fact, Dr. Bundren's reputation could only suffer if the ACOG peer review committee found the complaint to be valid.

Finally, the court found that Dr. Parriott could not be liable for damages in submitting his ACOG complaint, because the organization's grievance procedure is a "professional review action" within the meaning of the Health Care Quality Improvement Act.[5]

The Health Care Quality Improvement Act (HCQIA), *42 U.S.C. § 11101, et. seq*. provides:

> If a professional review action of a professional review body meets all the standards specified in …this title ...
> (B) any person acting as a member or staff to the body, . . . [and/or]
> (D) any person who participates with or assists the body with respect to the action, shall not be liable in damages under any law of the United States or of any State . . . with respect to the action.[9]

In this case, the Kansas court determined that providing medical testimony as an expert witness is professional conduct (i.e., the practice of medicine), that it is subject to a professional association's (ACOG) peer review process, and that the peer review falls within the scope and purpose of the Heath Care Quality Improvement Act, therefore, no action for damages can be sustained against Dr. Parriott.[5]

The Bundren decision is supported by the rather famous case of *Austin v. Association of Neurological Surgeons*, which the Kansas court cited, where the 7th Circuit Court of Appeals also found that expert witness testimony by a physician is a type of medical service within the meaning of the HCQIA.[10] The 7th Circuit held that:

> *"Although Dr. Austin did not treat the malpractice plaintiff for whom he testified, his testimony at her trial was a type of medical service and if the quality of his testimony reflected the quality of his medical judgment, he is probably a poor physician. His discipline by the Association therefore served an important public policy exemplified by the federal Health Care Quality Improvement Act which encourages … professional review."*[10]

The appellate court also commented on the difficulty a trial judge would have in discerning whether an expert's testimony conformed to acceptable professional standards:

> *"When a member of a prestigious professional association makes representations not on their face absurd, such as that a majority of neurosurgeons believe that a particular type of mishap is invariably the result of surgical negligence, the judge may have no basis for questioning the belief, even if the defendant's expert testifies to the contrary."*[10]

Most courts understand that experts use their membership in particular professional associations to bolster their credibility to the jury as an expert witness. The lawyers (for both the plaintiff and the defense) typically use such memberships to demonstrate the witness's experience and knowledge on the standard of care relevant to the litigation. As the 7th Circuit noted in the *Austin* case: "The Association [AANS] had an interest—the community at large had an interest—in Austin's not being able to use his membership to dazzle judges and juries and deflect the close and skeptical scrutiny that shoddy testimony deserves."[10]

The court concluded by saying, "We note finally that there is a strong national interest … in identifying and sanctioning poor-quality physicians and thereby improving the quality of health care."[10]

Any action taken against a testifying physician by a professional association may have major adverse consequences for the physician. Any suspension or expulsion from membership is an event required to be reported to the National Practitioners Databank.[5,10-12] Warnings, reprimands, or censures of the physician for inappropriate testimony are not reportable; however, they are discoverable in the litigation process.[10-12] Physicians sanctioned by their professional association will be effectively 'radioactive' and shunned by both plaintiff and defense attorneys in future med-mal litigation. Having to answer "Yes" to opposing counsel's question of "Doctor, have you ever been censured or sanctioned in any way by any professional association of your peers for giving false or misleading testimony in a medical malpractice case?" is no way to engender

credibility with a jury.

Today, most professional societies have developed policies or behavior guidelines for their members providing expert witnesses testimony in malpractice cases.[13] For example, like the ACOG, the American College of Emergency Physicians (ACEP), the American Society of General Surgeons, and the American Academy of Orthopedic Surgeons ask its members to execute an "Expert Witness Affirmation Statement." The affirmation document includes standards for the process of case review, limitation of testimony to areas of current clinical experience and competency, and the quality and integrity of the testimony provided.[14,15]

ACEP also has adopted Expert Witness Guidelines for the Specialty of Emergency Medicine,[16] which includes the following warning:

> *"Misconduct as an expert, including the provision of false, fraudulent, or misleading testimony, may expose the physician to disciplinary action."*[16]

Summary

These cases illustrate three major points:

1. Providing medical testimony is considered professional conduct, i.e., the practice of medicine;

2. Medical testimony is subject to the peer review process of physician professional associations; and

3. Those involved in the peer review processes of professional associations have immunity from suit under the federal HCQIA.

[*Editor's Note: Next month's article will address cases where state medical boards attempted to discipline a physician over scurrilous expert witness testimony given in medical malpractice lawsuits, and other avenues that physicians are utilizing to curtail such testimony.*]

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1. See generally Henry GL, Sullivan DJ (Eds). *Emergency Medicine Risk Management: A Comprehensive Review*. American College of Emergency Physicians, 2nd Ed 1997; Studdert DM, et al. Health Policy Report: Medical Malpractice. *NEJM* 2004;350:283-292; Mello MM, Studdert DM, Brennan TA. The New Medical Malpractice Crisis. *NEJM* 2003;348:2281-2284.
2. Under Kansas law, defamation is the communication to a third party of false and defamatory words that results in harm to the plaintiff's reputation. *Hall v Kansas Farm Bureau*, 50 P.3d 495, 504, 274 Kan. 263 (2002).
3. E.g., *Kahn v. Burman*, 878 F.2d 1436 (6th Cir. 1989).
4. *Fullerton v. Florida Medical Association*, Fla. 1st District Court of Appeal, (July 2006).
5. *Bundren v. Parriott*, US District Court for the District of Kansas, (June 2006).
6. American College of Obstetricians and Gynecologists Code of Professional Ethics (and expert witness guidelines). "The College (ACOG) considers unethical any expert testimony that is misleading because the witness does not have appropriate knowledge of the standard of care for the particular condition at the relevant time."
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8. *Bundren v. Parriott*, citing *Wilkinson v. Shoney 's, Inc*., 4 P.3d 1149, 1169, 269 Kan. 194 (2000).
9. The Health Care Quality Improvement Act (HCQIA), 42 U.S.C. §11112(a)(1).
10. *Austin v. American Association of Neurological Surgeons*, 253 F.3d 967 (7th Cir. 2001).
11. Sullivan W. Expert opinions: Defendants aren't the only ones on trial. *ED Legal Letter* 2004;15(9):97-108.
12. Sacopulos MJ. Addressing False Expert Witness Testimony in Medical Malpractice Litigation. *American Health Lawyers News* 2005;9(5):24-29. [Suspension or expulsion from a professional medical society is reportable to the National Practitioner Data Bank when they are based on reasons relating to professional conduct which could adversely affect the health of a patient.]
13. E.g., ACEP Policy Statement, Expert Witness Guidelines for the Specialty of Emergency Medicine, Policy #400114 Approved by the ACEP Board of Directors August 2000; American Academy of Pediatrics, Guidelines for Expert Witnesses in Medical Malpractice Litigation.
14. American Society of General Surgeons, ASGS Expert Witness Certification Program; American Academy of Orthopaedic Surgeons, Code of Medical Ethics and Professionalism for Orthopaedic Surgeons and Expert Witness Affirmation.
15. ACEP's expert witness reaffirmation statement is available at http://www.acep.org/NR/rdonlyres/2921BCEE-DA21-4784-94F9-A9198BA61399/0/Reaffirmation.pdf.
16. ACEP Policy Statement, Expert Witness Guidelines for the Specialty of Emergency Medicine, Policy #400114. ■

Know liability risks of 'drug seekers' and 'frequent fliers'

Commonly used terms are "no more appropriate than racial slurs"

by Staci Kusterbeck, Contributing Editor

[Editor's Note: This is the first in a two-part series on liability risks posed by patients who present to the ED frequently. This month, we'll cover documentation and clinical care of this patient population. Next month, we'll give strategies to avoid violations of the Emergency Medical Treatment and Labor Act.]

Almost every emergency department (ED) staff member is familiar with the terms "drug seekers"

and "frequent flyers"—derogatory terms referring to patients who are often viewed as nuisances. However, this attitude may increase risk of both adverse outcomes and lawsuits.

These labels can prevent accurate assessment and treatment of the patient, says **Daphne Walker**, JD, BSN, RN, an attorney with the Dallas, TX-based law firm Fulbright & Jaworski. "This is similar to the 'boy who cried wolf,' and can be a dangerous situation for the health care worker who is not on guard," she says.

The basic rule to follow is to avoid treating patients with frequent visits to your ED differently from any other patient. "You may think that a patient is probably a drug seeker, but what if they are not?" says **Linda M. Stimmel**, JD, a partner with the Dallas, TX-based law firm of Stewart Stimmel. "That is more of a concern. If there was any type of 'red flag' or mark on the chart of someone suspected to be a drug seeker, I would be concerned the staff would not give that patient the attention they would give any other patient."

If a plantiff's attorney asks "If you had not seen a drug history or suspected that the patient was drug seeking, would you have done anything differently for this patient?" you want the honest answer to be "no," says Stimmel.

Your biggest liability risk is failing to look beyond the label of "drug seeker" and provide the necessary evaluation and care for each individual presentation, says **Stephen A. Frew**, JD, vice president and risk consultant with Johnson Insurance Services, a Madison, WI-based company specializing in risk management for health care professionals. "When comments in the record evidence a hostile attitude or a judgmental or presumptive diagnosis, juries may consider this, which may influence the size of an award," says Frew.

A potential claim for failure to provide indicated pain relief could conceivably arise, but is more likely to be an add-on count for an adverse outcome to increase the value of the claim, says Frew.

Another risk lies in breaches of patient privacy regulations, both state and federal, that can result in institution liability and licensure or malpractice claims against the facility and the individual person committing the breach of privacy. For example, ED staff reporting the patient's name to a drug abuse hotline or "warning" others outside the patient's immediate care providers are both potential violations.

A third risk involves libel or slander. Typically, the standard is one of knowingly making a false statement, such as to an insurance company or employer, or including a statement that turns out to be false with a conscious disregard for whether it is true or false. "If a health care provider maliciously or judgmentally includes such a statement, significant liability could result," Frew says. "Damages in such a case could be substantial."

To reduce risks, do the following:

• Work with facts.

Patients may go to multiple EDs to obtain the specific drugs they are seeking, but there is no way for the staff to know that information unless told by the patient, says Stimmel. However, if a patient claims he/she is allergic to low-level pain medications in order to get narcotics, try to confirm this information if possible, she says.

"There is no foolproof method," says Stimmel. "If it is possible to check with the primary care physician, that is great. Still, we must be able to rely on what a patient tells us, if they appear competent. We do not have to be Sherlock Holmes but just show we were reasonable in our efforts."

If a physician has knowledge that the patient has no true allergies to low-level, non-narcotic pain medications, the physician has a right to take that into consideration when deciding on the choice of treatment for the patient, says Stimmel.

An ED physician should not be mandated to provide narcotic drugs, but must document all necessary clinical elements to justify the use of non-narcotics, adds Frew.

When there is concern about abuse, filling prescriptions or giving take-home doses, the number of doses provided should be limited to that necessary for the patient to make it to their regular physician or pharmacy, says Frew.

• Document objective facts only.

The terms 'frequent fliers' and 'drug seekers' reflect a judgment and non-compassionate attitude in the ED, says Frew. "They are no more appropriate than racial slurs," he says. "These labels are not recognized in court cases, and these patients — along with alcohol-

—continued on page 9

Key Points

Treating suspected "drug seekers" differently from any other patient in your ED increases risk of malpractice litigation, violation of federal regulations, and libel allegations. To reduce risks:

- Be cautious about flagging patient charts or speaking about patients in a derogatory way.
- Document objective findings only and avoid subjective impressions.
- Develop strategies to improve the care of frequent ED visitors as a group.

EMTALA Compliance Could Have Stopped Failure Cascade

by Stephen A. Frew, JD,
Vice President and Risk Consultant, Johnson Insurance Services

On January 6, 2006, well-known Washington, DC, journalist David Rosenbaum had wine and dinner with his wife, then picked up his music player and headphones and went out for a walk. Those decisions, coupled with massive problems with the District of Columbia EMS and hospital system, allegedly caused Mr. Rosenbaum's death and sparked DC and EMTALA investigations that put police, firefighters, and EMS and hospital ED personnel in an extremely 'bad light' and facing major legal actions. The frightening truth, however, is that this debacle could have occurred in any hospital in the United States that is not fully compliant with EMTALA. Similar situations could easily happen in your hospital.

Unlike most cases that are only seen by a few involved in the actual litigation or in the resulting EMTALA citation, the Rosenbaum case caused a political out-cry sufficient to bring the Office of Inspector General (OIG) for Washington, DC, into the matter to investigate the performance of all of the city departments and personnel involved in the case. Even more unusual, the OIG released the scathing report while the possibility of litigation still looms over all involved.

Failure Cascade

The OIG report describes extensive failures in the entire police, fire, EMS, and hospital personnel response to the event, with only the district's 9-1-1 office and medical examiner's office receiving passing grades.[1] (*Editor's Note: A full copy of the 42-page report of the Inspector General in the Rosenbaum case is available at www.medlaw.com/dcoig.pdf.*)

This is a classic example of how catastrophic outcomes are generally linked to a failure cascade — a total failure at every critical point in the process. This cascade or 'snowballing' effect of errors typically can be stopped by a single person exercising normal judgment, but oftentimes no one does.

Timeline of Events

The OIG report establishes a sequence and description from which it is possible to reconstruct a timeline of the events in the Rosenbaum case and illustrate the cascading errors that allegedly contributed to significant delays in Mr. Rosenbaum's care.

January 6, 2006

21:00 — David Rosenbaum left his home for a walk.

21:10 — A neighbor in the area goes to his car and finds a man unconscious on the sidewalk. The neighbor and other witnesses suspect a stroke because of poor motor control on one side of the body, inability to sit up, and inability to respond to questions. The victim is described as looking like he "belonged" in the area.

21:27 — 9-1-1 receives notification of a "man down"

21:28 — 9-1-1 notifies Fire Dispatch

21:30 — Fire dispatch dispatches Engine 20 and BLS Ambulance 18. Engine 20 is located approximately a half mile from the scene. Ambulance 18 is finishing a call at a hospital located approximately 5.6 miles from the scene.

21:31 — Police dispatch MPD unit 2022; Ambulance 18 acknowledges the call. Ambulance 18's driver protests having to take the call, then departs for the scene going the wrong way.

21:35 — Engine 20 arrives at the scene. The officer in charge of Engine 20 is an "acting" officer with no EMS training. The crew also has two EMT's and one EMT-advanced.

The Engine crew found the patient on his back, moving, and moaning. Some described the moans as "growls." Patient had no wallet or identification. The patient's music device was not found, but the headphones were lying nearby. The patient was unable to sit up; firefighters sat the patient up against their knees to examine him. He kept slumping to one side. Witnesses reported that the firefighters tended to a wound on the back of the victim's head, which was later corroborated by police statements, but firefighters denied or were inconsistent on whether a head wound was observed or treated.

Firefighters reported altered consciousness and constricted pupils. They applied oxygen to the patient at 25 liters per minute. The patient fought the mask and vomited. Firefighters reduced the oxygen level and the patient reportedly is less agitated. Firefighters disagreed whether there was an odor of alcohol, while one firefighter indicated a strong odor of alcohol. Civilian witnesses at the patient's side reported that they did not observe an odor of alcohol. The amount of vomiting is described as minor by witnesses, while at least one firefighter described it as more extensive and recurring.

Firefighters were inconsistent on who did what part of the exam on the patient, but agreed that no one firefighter conducted a complete assessment of the patient. The

patient was not immobilized prior to movement. The patient was not considered a potential diabetic patient because he did not have a Medic Alert or other medical tag or bracelet.

21:37 — Police unit 2021, which included a training officer and trainee, indicated that they will take the call. Unit 2022 continued to the scene but remained available for call. While on-scene, police did not take any statements, investigate the apparent robbery, or write a report following the call. Upon arrival, officers were advised by a firefighter that the patient was just an "ETOH"(the chemical name for ethanol) indicating an intoxicated individual.

21:40 — Ambulance 18 again advised it was en route. Engine 20 crew continued with patient assessment. There is an inconsistency among firefighters about whether vital signs were written down, on glove or paper, and by whom. The description of the patient included "pin-point" pupils and a Glascow Coma Scale score of "less than 8." (The OIG report does not include actual values).

21:53 — Ambulance 18 arrived on scene. They are advised by firefighters that the patient is "ETOH." Neither ambulance EMT examines the patient. The ambulance crew did not recall receiving any vital signs or information on head injury or coma scale values.

21:58 — Ambulance 18 departed scene. Driver refused to go to nearest hospital and elected to go to Howard Hospital, but left in the wrong direction, which added 5 minutes to the transport. The OIG report suggests that the reason for not going to the nearest hospital was that the driver had personal business in the Howard area. Firefighters returned to station, but did not complete any record of the call. Station log books examined by the OIG are said to appear to contain information added at a later date.

Arrival at Hospital

22:18 — Ambulance 18 arrived at the Howard Hospital ED. The ED was understaffed; all treatment rooms were occupied and stretchers were in the halls.

22:30 — Triage nurse signed in patient with chief complaint of ETOH and that he had "fallen" on the street. Triage nurse reports that she did not assess the patient because he was "asleep" and was told the patient was intoxicated. Coma scale score, pupils, skin integrity, and breath sounds were not assessed. Temperature was abnormally low. Triage notes show patient awake and alert, although nurse stated he was "asleep." Patient was placed in the hallway.

22:36 — Triage reported to charge nurse that patient was ETOH, not in distress, fell asleep, was upright on stretcher, not talking, had a normal pulse oxymetry, and was classified as level 3. On the basis of non-ambulatory or history of fall or intoxication the patient would be level 2 under the triage protocol. Unconscious would have been level 1 under the protocol.

23:00 — Physician maintained that she gave patient complete assessment. This time contradicts all other records. The physician told the OIG that the patient was white male, had vomit on face and blanket, was unkempt, and looked like typical alcoholic. She advised that she performed a head-to-toe assessment, found no injuries; patient was slumped, unresponsive, not talking, pupils were fine. All physician notes in record were illegible.

January 7, 2006

24:00 — Nurse taking another patient to a room passed Mr. Rosenbaum and noticed that Mr. Rosenbaum's breathing was characterized as a snoring, growling noise. No assessment since 22:36 although protocol required reassessment every 15 minutes. Nurse applied sternal rub, which produced inward posturing of limbs. Nurse observed that the patient had torn rear pants pocket, an expensive wrist watch, and a head laceration. The physician was notified, the patient was taken to the resuscitation room where it was observed that pupils were unequal and sluggish and breathing was shallow. Head injury was suspected. Patient placed on long spine board.

00:15 — Trauma team assumed care of patient.

Later that day, reports were received by police that Mr. Rosenbaum's credit cards had been used by an unauthorized person.

January 8, 2006

Mr. Rosenbaum died from head injuries sustained in an assault and robbery.

OIG Official Assessment

Although the OIG's report contains lengthy findings about the substandard service that was provided by police, fire, EMS, and Howard Hospital, and suggested many improvements, the following statement is the ultimate finding of the investigation.

"These multiple individual failures during the Rosenbaum emergency suggest alarming levels of complacency and indifference, which, if systemic, could undermine the effective, efficient, and high quality delivery of emergency services to District residents and visitors," Charles J. Willoughby, Inspector General wrote in his transmittal letter.

EMTALA Issues Rampant

Although the Centers for Medicare and Medicaid Services (CMS) report on its investigation has not been released, the Inspector General's report shows a number of critical EMTALA issues, issues that had they been addressed would have stopped the failure cascade two hours sooner, and perhaps could have prevented the fatal outcome.

Under CMS patterns of enforcement, citations would be likely for:

1. Failure to promptly provide triage at 22:18 – possible "parking" of the patient as warned against by subsequent CMS memo;
2. Failure to conduct a standard assessment per protocol;
3. Failure to properly classify the patient per triage protocol;
4. Failure to provide timely medical screening examination;
5. Failure to provide stabilizing care in a timely manner;
6. Failure to periodically reassess the patient per protocol
7. Failure to properly document compliant care, record illegible;
8. Possibly a conclusion that false information was provided by one or more hospital personnel.

Although the ED was busy, CMS probably would not allow that to excuse basic compliance standards, and also could raise the issue of adequate staffing under the Medicare Conditions of Participation.

The Ultimate Root Cause

While there are many elements of substandard performance addressed by the IG's report, there is one fundamental root-cause element that runs consistently through this entire case: a failure to consider patients with an odor of alcohol as "real patients."

This basic prejudice is pervasive in many EDs in the country, such that this exact episode could occur in almost any hospital in any community in the United States.

This tendency to afford delayed or substandard care to patients perceived as drunk or intoxicated has existed for my entire EMS/ED law career. It was substantial enough in 1988 that EMTALA was amended to include symptoms of substance abuse as a specific category of emergency medical condition and, thereby, mandate appropriate care for "drunks and druggies" in every ED in the country.

The force of this common prejudice is evident in the physician's description of the patient in terms that totally conflict with the objective view of concerned witnesses at the scene. This middle class professional who "looked like he belonged" in the good neighborhood, wore an expensive watch, and with a Glascow Coma Scale score of less than 8 was viewed by the physician as a typical unkempt, dirty, intoxicated alcoholic on the basis of four simple letters E-T-O-H.

On the basis of the IG's report, it appears that those same four letters prevented police, fire, and EMS personnel from considering the case serious from the beginning. Those letters appear to have lured a busy triage nurse into several critical errors that delayed Mr. Rosenbaum's care for hours. Those letters allowed good nurses and physicians to walk past Mr. Rosenbaum as he deteriorated without even really noticing him for hours.

Conclusion

EMTALA requires possibly intoxicated patients to first be screened to determine whether they have any medical, toxic, or traumatic conditions that might have caused or might be masked by the apparent intoxicated state. Citations have been issued for discharges before a patient's sobriety level reached a point where reliable neurological assessments can be performed.

From an EMTALA compliance perspective and from a medical malpractice exposure, patients who are perceived as intoxicated represent a significant risk to hospital EDs, EMS, and police agencies. Failure to appreciate this fact can and will result in catastrophic events like the Rosenbaum case.

It is the legal responsibility of hospitals and ED personnel to ensure that ETOH is not accepted as a diagnosis from the field, is not allowed to affect care in the ED, and is considered an elevated risk element in all presenting patients. No one should die in a U.S. hospital because he/she had wine with dinner.

References

1. Government of the District of Columbia Office of the Inspector General. Summary of Special Report: Emergency Response to the Assault on David E. Rosenbaum. OIG No. 06-I-003-UC-FB-FA-FX. June 2006. ■

continued from page 5
intoxicated patients — are the very ones who will result in lawsuits and citations," he adds.

The words should never appear in a medical record unless they came out of the patient's mouth — and then they should be written down verbatim and enclosed with quote marks, says Frew. "ED humor often isn't humorous to patients and their families, and should be handled in the same manner with staff as potentially offensive sexual jokes, racial slurs, or political comments," he says.

Statements about drug seeking behavior should never appear in the patient's chart, says **Sandra Schneider**, MD, ED physician at the hospital and professor of emergency medicine at University of Rochester (NY). "Instead, the behavior should be factually described and the conclusion left up to the reader."

For example, the ED physician could document, 'This is the 15th visit in two months by Mrs. Smith asking for pain medication."

Never document subjectively, and always document objectively, advises Stimmel. "If the patient leaves the ED, without treatment and has a bad outcome, do we have liability risk if we called them a drug seeker? I would be in a much more difficult position defending an ED physician if the patient had been labeled in any way," says Stimmel.

An objective assessment based on clinical indications and known patient history must prevail over any subjective supposition about the patient's intentions, Walker says. "Unfortunately, patients can sue for any or no reason at all. However, damages must be proven at trial, and adequate documentation is the physician's best proof that he or she properly assessed and treated the patient," she says.

It is never appropriate to speak of a patient in a derogatory manner, especially when the patient, the patient's family, or other patients might overhear, says Walker. "A simple slip of the tongue may undo all that the physician tried to do in objective clinical assessment and documentation," she says.

• Always document that patients were referred.

If you tell the patient to see her physician on Monday, she does not follow up and has an adverse outcome, that patient may sue the ED for medical negligence, says Stimmel. "I have defended lawsuits based on that scenario," she says. "If the fact that the patient was told to follow up is correctly documented in the chart, it makes the lawsuit very defensible." Stimmel suggests writing the recommendation for follow-up care on the patient's discharge instructions and requiring the patient to sign-off on the instructions, verifying they received the information.

• Identify frequent visitors with a quality improvement focus.

What's the single best method of deterring drug seeking patients from coming to your ED? Provide a thorough examination, document thoroughly, and have a uniform approach to what justifies drug prescription in the ED, says Frew.

"If all of the physicians politely stick to the same objective standards, persons seeking drugs learn your facility is not susceptible to 'doctor shopping' and go elsewhere," he says.

Another approach is to call in a psychiatrist or pain specialist to evaluate the patient if you're uncertain about whether the patient needs narcotic painkillers. "Actual drug seekers are often intimidated with the risk of psychiatric admission," says Frew.

Flagging an individual patient's chart in any way is a bad practice—instead, develop strategies to reduce visits and improve outcomes of frequent ED visitors as a group. "For example, if a patient is in a group of patients who have five visits each month, you can look at why they came in, what are their different issues, and what can you do better to work with these patients," says **Mary Jean Geroulo**, JD, a health care attorney with Stewart Stimmel.

Patients with multiple presentations are at increased risk for both errors and selection of these cases for compliance review by regulatory agencies, says Frew. "Tracking should be by quality mechanisms to assure the proper attitude toward the visits," says Frew.

For instance, examining physicians should specifically reference prior charts in their current assessment, and note similarities and differences as itemized observations without a judgmental tone, he says. "But prior testing that may have changed in the interim should be redone for EMTALA compliance purposes," says Frew.

University of Rochester's ED is currently working on protocols to differentiate chronic pain from acute pain and neuropathic pain from other types of pain, with the goal of improving care in this patient population, says Schneider. Chronic pain management calls for long-lasting medications such as methadone or fentanyl patches, whereas acute pain requires medications taken every 4-6 hours, she explains.

"Neuropathic pain does not respond well to narcotics and often requires tricyclics or neurontin," says Schneider. "There is some evidence that poorly controlled acute pain contributes to chronic pain syndromes."

Patients who come to the ED frequently should have individualized protocols, preferably developed by the patient and his/her primary care physician, at a time his/her pain is under control, says Schneider. The protocol should outline exactly what pain medication, the amount, and the frequency the patient will be given, and also the amount of prescription medication

the patient will receive at discharge. "Such a protocol decreases the tension over the visit and decreases length of stay," says Schneider.

However, EDs still have a responsibility to not enable prescription drug diversion or to allow someone's abuse of the health system and themselves to go unchecked, says **Larry B. Mellick**, MD, MS, FAAP, FACEP, professor of emergency medicine and pediatrics at Medical College of Georgia in Augusta. He suggests the following strategies:

- Show or report verbally to the patient a list of visits and the specific complaints and point out that the visits raise important questions. Have a specific conversation with the patient about his/her multiple visits to the ED, and document this conversation in the chart.
- Consider asking the patient directly if he/she suspects that he/she may be dependent on narcotics or have a history of drug dependency in the past, and document the patient's exact words in the chart.
- Use your resources to confirm the patient's story whenever possible. Whenever a patient states he/she has an appointment with the pain clinic or a specialist, a staff member could call and confirm. "If, as often is the case, the patient's report is not accurate, document this in the chart," says Mellick.
- If the patient states he/she is visiting from out of town, have the clerical staff confirm the address and telephone number provided. If these are not accurate, document this information in the chart.
- Document in the chart statements that raise 'red flags', such as an additional and unrelated request to the nurse for Hycodan® cough medicine at the time of discharge. "The requests of these patient's will often change, expand, or show contradictions." says Mellick. ■

Some EPs unfamiliar with MI guidelines

Liability risk is "significant" if staff don't follow current recommendations

by Staci Kusterbeck, Contributing Editor

A recent study has revealed that 28% of 509 emergency physicians (EPs) surveyed were not at all familiar, or only somewhat familiar, with the 2004 American College of Cardiology (ACC)/American Heart Association (AHA) guidelines for the Management of Patients with ST-Elevation Myocardial Infarction (STEMI).[1]

"We found a lack of physician awareness of national treatment guidelines in the U.S., which means many patients may not be receiving the lifesaving treatments they need in a timely manner," says **W. Frank Peacock**, MD, the study's lead author and vice chief of emergency medicine research at The Cleveland (OH) Clinic Foundation.

Since the goal of treatment is to minimize damage to the heart muscle caused by a lack of blood flow stemming from a clogged artery, each minute that ticks by without treatment translates to more damage, disability and potential death, says Peacock.

The STEMI guidelines recommend mechanical reperfusion via percutaneous coronary intervention (PCI) if a patient can undergo the procedure within 90 minutes, known as the door-to-balloon time. If a patient cannot undergo PCI within this 90-minute timeframe, the guidelines recommend pharmacologic reperfusion via fibrinolytic therapy within 30 minutes, known as the door-to-needle time.

However, 51% of the EPs surveyed said that fibrinolysis-eligible patients would only sometimes, rarely, or never receive a fibrinolytic agent when the time to PCI exceeds 90 minutes. Nearly 70% of the physicians surveyed reported that it is not realistic that STEMI patients can undergo PCI within 90 minutes of medical contact for cases when patients need to be transferred to a PCI-capable hospital.

It was surprising that so many physicians admitted to being unfamiliar with the guidelines, says Peacock. "These are the best-referenced guidelines for the care of heart attack in the nation. They are the most evidence-based recommendations that exist," he says. In fact, the actual number of physicians unfamiliar with the guidelines is much higher than 28%, according to Peacock. "What was really surprising was that only 8% were able to identify the correct recommendation regarding treatment within the first 3 hours," says Peacock. "So although 72% thought they knew the guidelines, the overwhelming majority did not." Of those who said they knew the preferred strategy, 88% selected PCI and 4% selected fibrinolytic administration.

In actuality, neither strategy is preferred, which is an important distinction because it means that any delay in one procedure should prompt the immediate performance of the other, says Peacock. "Right now we have this bias toward intervention with the OR as opposed to opening of the arteries," he says. "It's all geared toward getting coronary intervention done, and that is only beneficial if it's done quickly. If it's done late, it's less than optimal."

Litigation regarding the diagnosis and treatment of myocardial infarction results in some of the largest monetary awards that emergency physicians encounter, says Peacock. "Liabilities are significant,"

says Peacock. "Patients with a bad outcome whose care does not adhere to guidelines represent the greatest risk for the hospital." Missed heart attack is not the most common award involving ED malpractice lawsuits, but it is the largest award, he notes. "It's even worse to get the diagnosis and not follow the guidelines," says Peacock. "Not knowing the recommended diagnostic and treatment strategies for this very common and very high-risk condition is just plain stupid."

There are indeed significant liability implications for EDs if the STEMI guidelines are not followed, 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.

Physicians are presumed to know the appropriate treatment for any condition, so lack of knowledge of the standard of care will put physicians in a "very risky position" if patient injury occurs, says Liang.

This is particularly true for heart attack patients coming to the ED, says Liang. "First, there is a significant risk of patient injury in these circumstances, and thus significant damages at stake. Second, these are national, highly respected guidelines that are published and available to ED physicians," he says. Since ED patients with cardiac symptoms are at risk for significant disability and death if not treated appropriately, there is an urgent need for ED personnel to be well-versed in the recommendations, says Liang.

"Appropriately structured quality improvement activities may be effective because they create a reason to pay attention to education," says Peacock. For example, objectively measure several process-dependent outcomes, such as time to treatment, time to diagnosis, and examine why specific treatments were selected. "With this method, where improvement is needed will become apparent," Peacock says. "Have an educational initiative for the staff. Then re-measure the outcomes to determine if the system is meeting the objectives, or if further work and education is needed."

ED directors and managers should survey staff, then create in-service training to address any knowledge gaps that exist, says Lang. "EDs must ensure that staff are well aware of important guidelines for this and other treatments," says Liang. "This is a systemic issue that needs to be addressed systemically."

Key Points

A survey of emergency physicians showed that 28% were not at all familiar or only somewhat familiar with treatment guidelines for patients with ST-elevation myocardial infarction. Only 8% were able to identify the correct recommendation for treatment within the first three hours. The findings are a 'red flag' for increased liability risks. To address this in your ED:

- Measure time-to-treatment, time-to-diagnosis, and examine why specific treatments were selected.
- Survey ED staff about their familiarity with current recommendations.
- Provide in-service education to staff based on any knowledge gaps that are identified.

Reference

1. Peacock W, Bhatt D, Diercks D, et al. American College of Cardiology (ACC)/American Heart Association (AHA) guidelines for the management of patients with ST-elevation myocardial infarction: Cardiologist and emergency physician opinions and knowledge. *Ann Emerg Med* 2006:48(4):S29. ■

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. ■

CME/CNE *Questions*

1. Which one of the following is recommended to reduce risks of patients with frequent visits to the ED?
   A. Implement a separate policy for assessment and treatment of suspected drug seekers.
   B. Document the words "drug seeking behavior" in the patient's chart to alert other staff.
   C. Avoid treating suspected drug seekers differently from any other patients.
   D. Mark or flag the patient's chart in a prominent way.
2. Which of the following could result in increased liability risks if drug-seeking behavior is suspected?
   A. Reporting the patient to a drug abuse hotline if drug-seeking behavior is suspected.
   B. Failing to give patients pain medication if the physician does not feel it's warranted.
   C. Doing a routine allergy check to verify a patient's claim that he/she is allergic to non-narcotic pain medications.
   D. Limiting doses to only the amount of medication to allow the patient to make it to their regular physician or pharmacy.

3. What did a recent survey find regarding physician knowledge of myocardial infarction guidelines?
   A. None of the physicians said they were unfamiliar with current treatment recommendations.
   B. Less than half correctly identified recommendations for treatment within the first 3 hours.
   C. All respondents indicated that eligible patients would always receive a fibrinolytic when the time to percutaneous coronary intervention (PCI) exceeds 90 minutes.
   D. No problems were reported for undergoing PCI within 90 minutes.

4. Which one of the following statements regarding expert witness testimony is true?
   A. Providing medical testimony is considered professional conduct.
   B. Medical testimony is subject to the peer review process of physician professional associations.
   C. Those involved in the peer review processes of professional associations have immunity from suit under the federal Health Care Quality Improvement Act.
   D. All of the above

Answers:
1. C
2. A
3. B
4: D

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This issue of your newsletter marks the start of a new continuing medical education (CME) or continuing nursing education (CNE) semester and provides us with an opportunity to review the procedures.

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3. Integrate practical solutions to reduce risk into the ED practitioner's daily practices.

Each issue of your newsletter contains questions relating to the information provided in that issue. After reading the issue, answer the questions at the end of the issue to the best of your ability. You can then compare your answers with the correct answers provided in an answer key in the newsletter. If any of your answers were incorrect, please refer back to the source material to clarify any misunderstanding.

This activity is valid 24 months from the date of publication. The target audience for this activity is emergency medicine physicians and nurses and risk managers.

Those participants who earn nursing contact hours through this activity will note that the number of contact hours is decreasing to 15 annually. This change is due to the mandatory implementation of a 60-minute contact hour as dictated by the American Nurses Credentialing Center. Previously, a 50-minute contact hour was used. AHC Media LLC is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

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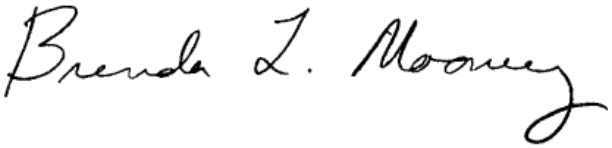

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