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IN THIS ISSUE

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Incident Reports: How to avoid plaintiff attorneys using them against you

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

Many health care providers harbor the delusion that hospital 'incident reports,' or 'occurrence screens,' are privileged and protected from discovery or admission as evidence against them in malpractice litigation. A rash of recent court decisions dispels that notion, and understanding the underpinnings of the courts' reasoning may help hospitals and emergency departments fashion procedures that circumvent the disclosure or admissibility of these materials in civil litigation.

Incident reports not protected under state peer-review statutes

Riverside Hosp. Inc. v. Johnson.[1] Elaine Johnson, 79 years old and suffering from known lymphoma, was admitted to Riverside Hospital for new-onset altered mental status and generalized weakness. The initial nursing assessment evaluated Ms. Johnson's risk of falling, based on pre-defined factors. The nurse did not identify Ms. Johnson as a high fall risk patient, and consequently did not initiate the hospital's fall prevention procedures for Ms. Johnson. Shortly after admission, however, Ms. Johnson fell in the hallway outside her room and fractured her hip. She died a month or so later due to her lymphoma (not from complications of the fractured hip).

The family sued the hospital and the nurse, seeking $1 million in compensatory damages and $350,000 in punitive damages, for failure to accurately assess Ms. Johnson's risk of falling and failure to utilized appropriate measures to prevent her from falling, such as restraints, bottom bed rails, a bed check alarm, or a prompt and reliable nurse call system.[1]

The nurse stated she placed a call bell within Ms. Johnson's reach and that the top rails were in place on the bed. She did not install a bed alarm, which would have sounded had the patient gotten out of bed unassisted. Instead, she told Ms. Johnson not to leave the bed without assistance and to use the call system to summon help when getting up.

After the fall, the nurse completed an incident report which indicated the date, place, and time of the fall; the severity of the fall; the facts of the fall; whether the patient was aware of the fall and her reaction to it; and her status before the fall, including the use of any restraints, side rails, or call bell. It also included an entry with nursing conclusions regarding the patient's abnormal mental status, state of confusion, and unsteady gait. The court allowed the incident report to be presented

to the jury as evidence for the plaintiff against the hospital and the nurse, and the jury returned a verdict in favor of the family for $1million.

On appeal to the Supreme Court of Virginia, the hospital objected to the trial court admitting the incident report into evidence, claiming that the report was a 'Quality Care Control Report' (QCCR), part of the hospital's quality control process, and, therefore, privileged and exempt from disclosure under the states' peer review statutes.[1,2]

The family replied that the QCCRs were actually routine accident reports that were designated as quality care control documents in an attempt to invoke the privilege afforded under Virginia law.[3] Such information, the family argued, should not be entitled to the privilege under the law merely because it may be ultimately reviewed by a medical staff, quality assurance, peer review, or other type of committee identified in the statute.[2,3]

The court scrutinized two sections of the Virginia Peer Review statute in considering its decision:

First, the primary protection section, which states:

> "The proceedings, minutes, records, and reports of any medical staff committee, utilization review committee, ... quality assurance, quality of care, or peer review committee, together with all communications, both oral and written, originating in or provided to such committees ... are privileged communications which may not be disclosed or obtained by legal discovery proceedings unless a circuit court, after a hearing and for good cause ... orders the disclosure of such proceedings, minutes, records, reports, or communications.[3]

The court then noted that the incident report at issue was not a document *generated by* a peer review or other quality care committee referred to in the statute; therefore, it was not a proceeding, minutes, report, or other communication "of" or "originating in" such committees. Thus, the question became whether the incident report qualified for the privilege because it was "communications ... provided to" such peer review or quality care committees. It would appear this language provides protection to the hospital's QCCRs if they are included in the peer review process; however, another section of the statute contains an exception clause:

> "Nothing in this section shall be construed as providing any privilege to health care provider ... medical records kept with respect to any patient in the ordinary course of business of operating a hospital ... nor to any facts or information contained in such records."[4]

Indeed, the hospital's director of risk management had testified that the QCCR was a report that the nurse prepared "in the course of her job," and that a QCCR would be completed for all falls regardless of whether there was an injury or whether litigation was expected. The director also stated that QCCR's were generated for the purpose of "improvement efforts" and were typically discarded after 30 days.[1]

However, in this case the hospital retained the QCCR describing Johnson's fall specifically because it anticipated litigation would ensue, and it argued that

Clarification

The credential information for Drs. Moore and Pfaff were inadvertently left out of the February 2007 issue of *ED Legal Letter*. They co-authored an article in that issue. The following should have been listed: **Gregory P. Moore, MD, JD,** Attending Physician Emergency Department, Kaiser Permanente Sacramento/Roseville, CA; Volunteer Clinical Faculty, Emergency Medicine Residency, University of California-Davis School of Medicine; and **James A. Pfaff, MD, FACEP, FAAEM,** Staff Physician, San Antonio Uniformed Health Services Health Education Consortium.

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the information on the QCCR was a 'qualitative analysis' of Johnson's fall that should be protected by the statute. The plaintiffs claimed the QCCR did not contain any qualitative information about the incident, only the 'factual circumstances' of the fall.[1]

The court quoted itself in reviewing the purpose of the privilege:

> "The obvious legislative intent [of the statute] is to promote open and frank discussion during the peer review process among health care providers in furtherance of the overall goal of improvement of the health care system. If peer review information were not confidential, there would be little incentive to participate in the process."[5]

It then stated that it is the deliberative process and the conclusions reached through that process that the legislature sought to protect, not the facts which gave rise to the issue.[6]

The court determined that the QCCR, or incident report, was a written documentation of the circumstances of Johnson's fall kept in the normal course of business — a factual recitation of a fall that occurred during Johnson's hospitalization and the immediate action taken when Johnson was found on the floor. The court stated that "factual patient care incident information does not contain or reflect any committee discussion or action by the committee reviewing the information and is not the type of information that must 'necessarily be confidential' to allow participation in the peer or quality assurance review process." Instead, it decided that such information is the type contemplated by the exception clause of the statute, which the legislature specifically intended to not be within the scope of those items entitled to the privilege under the first part of the statute.[4]

The court felt that this limitation on the application of the privilege was consistent with preserving the confidentiality of the quality review process while allowing disclosure of relevant information regarding specific patient care and treatment.

In summary, the Virginia Supreme Court held that incident reports presented to the hospital's quality control committee were not privileged under the states' peer review statutes because they were factual information collected in the ordinary course of business and operations of the hospital.[1]

Incident reports not protected under attorney-client privilege in anticipation of litigation

Long v. Women and Infant Hospital of Rhode Island.[7] In this wrongful death action, the plaintiff parents filed a motion to compel the hospital to produce an occurrence screen that was prepared by a nurse after their prematurely-born son died during treatment in the hospital's neonatal intensive care unit.

The hospital argued that its occurrence screens were protected from discovery under the attorney-client privilege because they were made in anticipation of litigation, stating:

> "It is hospital policy not to produce these [occurrence screens] inasmuch as they are made in anticipation of litigation. It is believed that suits are brought many times just when there is an unfortunate outcome without any malpractice."[7]

The plaintiffs contended that the occurrence screen was not privileged because such reports are prepared routinely and in the ordinary course of business.[8]

Counsel for the hospital countered, stating that "we only fill this form out for unusual circumstances not what we would see in the normal course of business ... "[7] But the court noted that the hospital completed the occurrence screens for incidents where no injury whatsoever resulted, and in such situations it would be highly unlikely that any litigation would ensue, undermining the hospital's assertion that the occurrence screens are prepared in contemplation of litigation. The court ordered the hospital to provide a copy of the occurrence screen to the plaintiffs.[7,9,10]

Incident reports not protected under federal peer review statutes

Atteberry v. Longmont United Hospital.[11] Scott Atteberry arrived in Longmont United Hospital emergency room in hypovolemic shock after a motorcycle accident. The emergency physician and a trauma surgeon treated Mr. Atteberry in the ED for 3 hours. The surgeon then attempted to transfer him via helicopter to a major trauma center in Denver, but he died in route, allegedly from internal hemorrhaging.

Scott's mother sued the hospital in state court under the Emergency Medical Treatment and Active Labor Act (EMTALA).[12] She claimed that the hospital failed to stabilize her son's emergency medical condition (EMC), failed to provide medical treatment to minimize his risks of transfer, failed to certify in writing as required by the law that the benefits of transfer outweighed the risks of transfer (which the defendant admitted),[13] and transferred him in an unstable condition in violation of the act.[11] She also filed a state law claim for professional negligence against the trauma surgeon for failing to take her son to the operating room to stop his bleeding and for transferring him in an unstable condition. The hospital removed the case out of state court into federal district court.[11,14]

At issue in this case was whether the plaintiff could compel the hospital to produce any quality assurance reports, peer review reports or morbidity/mortality reports related to Mr. Atteberry's care at Longmont hospital.[11]

The hospital objected to producing the materials, asserting that the requested information was protected from discovery by the federal Health Care Quality

Improvement Act (HCQIA),[15] the Colorado state peer review privilege,[16] and a number of other privileges.[17]

Federal Health Care Quality Improvement Act (HCQIA). The court then addressed whether the asserted privileges applied. It first summarily dismissed the HCQIA defense, noting that the courts repeatedly have held that HCQIA does not create a federal statutory privilege and that there is no historical or statutory basis for a peer review materials privilege.[18] It cited one illustrative example:

> "The federal Health Care Quality Improvement Act of 1986 provides qualified immunity for persons providing information to a professional review body regarding the competence or professional conduct of a physician.[19] It also established confidentiality for information reported under the act, but did not establish confidentiality for peer review records or protect peer review records and materials from discovery and court subpoena. The absence of such a privilege in this statute is evidence that Congress did not intend these records to have the level of confidentiality and protection advanced by the hospitals and provided in the state statute."[20]

And then the court repeated an oft-cited quote in federal cases that "Congress spoke loudly with its silence in not including a privilege against discovery of peer review materials in the HCQIA."[21]

Colorado State Law Privileges. In federal court, discovery is governed by the Federal Rules of Civil Procedure, not state rules. The Federal Rules define the scope of discovery as follows:

> "Parties may obtain discovery regarding any matter, not privileged, which is relevant to the subject matter involved in the pending action ... The information sought need not be admissible at trial if the information sought appears reasonably calculated to lead to the discovery of admissible evidence."[22]

Also, when in federal court the federal rules of evidence and the federal common law of privileges apply, not the corresponding state rules.[11] EMTALA is a federal claim, and whenever federal law provides the governing substantive law in a lawsuit, the court looks to the federal common law of privileges to determine whether the requested materials are privileged.[11,23]

The court said that neither the United States Supreme Court nor the Tenth Circuit Court of Appeals has recognized a medical peer review or medical risk management privilege under federal common law.[24] To the contrary, it noted that every legislative and controlling judicial indication was that federal policy, under these circumstances, opposes recognition of the quality management and peer review privileges enacted by the State of Colorado.[25]

Therefore, the court ordered the hospital to turn over its quality assurance, peer review, and morbidity/mortality materials related to Mr. Atteberry's care to the plaintiffs.[11,26]

Postscript. The adverse ruling against the hospital in this case could have been prevented. The case was originally filed in state court, and the hospital was not required to remove it to federal court. If it had allowed the case remain in state court, the Colorado peer review protections for these materials would almost certainly have applied. The hospital's reasons for moving the case to federal court aren't known from the court opinion, and it's possible they outweighed the loss of the peer review protections; however, this case highlights the risk and the issues one must consider before fleeing state court juries or judges.

Policy options to consider regarding collection of occurrence data

1. Eliminate the use of incident reports. The practice is an anachronism and today rarely serves a necessary purpose. The hospital staff already know the areas of risk in the ED and hospital settings, and everyone fully expects the hospital and involved physicians to be sued for any unexpected adverse result that occurs in the ED (or hospital) regardless of whether true negligence was the causative factor.
2. Bifurcate collection of "incident reports" from data collected in "anticipation of litigation." Only prepare an "incident report" when no harm came to the patient and litigation is not even remotely expected. If the patient incurred injury as a result of an incident, or the hospital staff believe litigation is possible, then the information should be shared only with the hospital attorney's office. Under no circumstances should the hospital use the same forms or the same process as the "incident reporting" system and no "incident report" should be generated in these circumstances. The intent is to clearly protect information under the attorney-client privilege.
3. Never allow cases of potential EMTALA violations/claims to go through the hospital's peer review process. Instead, always submit EMTALA issues directly to hospital counsel for review to establish the attorney-client/"in anticipation of litigation" privilege. The attorney can involve the appropriate medical staff in review of the case, and the educational "peer-review" benefits can still be gleaned from the case, but the potential damaging substantive deliberations can be protected from discovery in civil litigation in federal court.
4. Establish a "patient safety evaluation system" and create or affiliate with a "patient safety organization" (PSO) under the Patient Safety and Quality Improvement Act of 2005 (PSQIA).[27] This new federal law provides broad strong federal privilege protections for medical peer-review activities if done

according to the strict guidelines outlined in the Act. The PSQIA has the potential to overcome the inherent weaknesses of state peer review protections themselves and eliminate the jurisdictional problem of the federal courts not recognizing state peer-review statutes. However, to date, both hospitals and physicians have been very reticent to establish PSOs because the government has not yet written regulations implementing the law. More on the PSQIA will be forthcoming in future issues. ■

References

1. *Riverside Hosp. Inc. v. Johnson*, 636 S.E.2d 416 (Va. Nov. 3, 2006)
2. Va. Code § 8.01-581.17.
3. VA. Code § 8.01-581.17(B).
4. VA. Code § 8.01-581.17(C).
5. Citing HCA Health Services of Virginia, Inc. v. Levin, 530 S.E.2d 417, 420 (VA. 2000).
6. VA. Code § 8.01-581.16 (provides immunity for persons involved in the peer review process).
7. *Long v. Women and Infants Hosp. of Rhode Island*, No.: PC/03-0589; C.A. NO.: PC/05-4465, 2006 R.I. Super. LEXIS 124 (September 11, 2006).
8. See Super. R. Civ. P. Rule 26(b)(1).
9. *Columbia/HCA Healthcare Corp. v. The 8th Judicial District Court of Nevada*, 936 P.2d 844 (Nev. 1977). Incident reports prepared in the ordinary course of business not protected under the attorney-client privilege
10. *Diggs v. Novant Health,* 628 S.E.2d 851 (NC. App. 2006). Incident reports not privileged.
11. A*tteberry v. Longmont United Hosp*., 221 F.R.D. 644 (D. Col. 2004).
12. 42 USC §1395dd.
13. 42 USC §1395dd(c)(1)(A)(ii) or (iii).
14. EMTALA claims may be filed in either state court or federal court, at the discretion of the plaintiff (which is called 'concurrent jurisdiction'). However, if the plaintiff files a federal claim in state court, such as an EMTALA claim, the defendant has the legal right (option) to 'remove' the case into federal court. There a host of reasons why either party would prefer to be in one court or the other, such as jury pool, quality of the judges, or the differing rules of evidence or civil procedure. See generally the Civil Litigation chapter in Bitterman, RA. Providing Emergency Care under Federal Law: EMTALA. Published by ACEP 2001/2004.
15. 42 U.S.C. § 11101, et seq.
16. C.R.S. 12-36.5-104.
17. The other privileges averred included the attorney-client privilege and the attorney work product doctrine, but the court dismissed these privileges because the hospital didn't present them properly in its briefs. The federal courts do recognize these privileges when conducted and asserted correctly.
18. *E.g. Robertson v. Neuromedical Center*, 169 F.R.D. 80, 82-82 (M.D. La. 1996). Accord, *Poliner v. Texas Health Systems*, 201 F.R.D. 437, 438 (N.D. Tex. 2001), noting that the HCQIA does not create a bar to discovery of materials relating to peer review committees.
19. 42 U.S.C. §11111(a).
20. 169 F.R.D. 80, 82-82 (M.D. La. 1996).
21. See e.g., *United States v. QHG of Indiana, Inc.*, 1998 U.S. Dist. LEXIS 23512 (N.D. Ind. Oct. 8, 1998); and *Syposs v. United States,* 179 F.R.D. 406 (W.D.N.Y. 1998), noting that no federal statutory peer review privilege exists under the HCQIA.
22. Rule 26(b)(1), Fed. R. Civ. Procedure.
23. The federal law of privilege governs even where the evidence sought also may be relevant to pendent state law claims, such as professional negligence claims. E.g., Hancock v. Hobbs, 967 F.2d 462, 466-67 (11th Cir. 1992).
24. Citing *Sonnino v. University of Kansas Hosp. Authority*, 220 F.R.D. 633, 644 (D. Kan. 2004).
25. Citing *Patt v. Family Health Systems, Inc.,* 189 F.R.D. 518 (E.D. Wis. 1999), aff'd 280 F.3d 749 (7th Cir. 2002).
26. *Smith v. Botsford General Hospital*, 419 F.3d 513 (6th Cir. 2005). See Bitterman RA. Michigan's non-economic damages cap ruled constitutional; the cap applies to EMTALA claims. *EDLegal Letter* 2006;17:109-113.
27. Patient Safety and Quality Improvement Act of 2005, Pub. Law No. 109-41.

Change of shift high-risk for ED patients

Communication lapses can cause adverse outcomes and lawsuits

by Stacey Kusterbeck, Contributing Editor

Both nurses and physicians are at high risk for communication lapses during change of shift, says **Francis L. Counselman**, MD, chairman and program director for the department of emergency medicine at Eastern Virginia Medical School. The departing physician often is anxious to leave and does not have the same degree of vigilance for that last patient of the day, he explains. As a result, all of the necessary information may not be communicated to the physician taking over the patient. "The arriving physician often never examines the patient, or does not really consider the patient 'theirs,'" he says. "There is often no sense of 'ownership' of the patient for the physician coming on."

Similarly, orders at the very end of a nurse's shift may not get done, yet the nurse coming on may assume they have been done. "The bottom line is that the order is not performed," says Counselman. "Another scenario is a compulsive nurse completes all of the orders on her patient such as hanging medications, but forgets to document these actions." The nurse coming on does not think the medication has been given and administers it, so the patient receives two doses.

The absolute worst scenario is when both physicians and nurses change shift at the same time, says Counselman. "There is then no caregiver who has a full understanding of the patient."

Improve communication

Information related to patient plan of care, diagnosis, and suspected complications is essential to safe

—continued on page 68

SPECIAL REPORT

AMA Discharges

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

When a physician and patient disagree about medical testing and treatment, in most circumstances the patient has the right to refuse further care, even if that refusal may result in the patient's death. But a patient's refusal of care must be an informed decision, since both the patient and the physician may be at risk: Patients who leave AMA are seven times as likely to be readmitted in the following 15 days[1] and physicians may be sued both for treating patients against their will and for allowing patients to leave without treatment.

Why do patients leave AMA?

No specific demographics identify patients who are likely to leave AMA.[2] One study showed that lack of a primary care physician and previous AMA discharges were the only factors associated with leaving AMA. Similarly, patients who leave the emergency department (ED) without being seen are less likely to have insurance and are more likely to be younger in age, to have less severe medical problems, and to have left without being seen in the previous 12 months.[3]

Patients who leave AMA commonly cite one of several reasons for leaving, including personal or family issues, financial concerns, feeling well enough to leave, dissatisfaction with the physician or treatment received, becoming "fed up," and dislike of hospitals in general. Understanding the reasoning behind[2,3] a patient's decision to leave AMA can be an important factor in helping to convince the patient that proceeding with proposed care is the most reasonable course of action.

What are legal issues regarding AMA discharges?

In a medical malpractice case, the patient alleges that the medical provider was negligent and that the medical provider's negligence caused the patient to sustain some type of injury. One way to counter the patient's allegations is to allege that the patient's actions (or inactions) caused his or her own injuries—in other words, alleging that the plaintiff was "contributorily negligent." Refusing to submit to recommended testing and treatment and leaving AMA may be the sole cause of a patient's injuries. Informed refusal of care may, therefore, mitigate or completely eliminate the healthcare provider's liability. But there are several requirements that must be met before a healthcare provider can successfully raise this contributory negligence defense.

Patient capacity

Patients who refuse treatment must have the capacity to make a decision. Legal capacity generally requires that a patient be at least 18 years old or that the patient be an "emancipated minor." Each practitioner should be familiar with the definition of legal capacity used in his or her state. Clinical or "decision-making" capacity generally requires that a patient be able to understand the diagnosis, the proposed medical care, and the implications of proceeding with or refusing such care. While exceptions may exist (for example, "mature minors"), in general, patients should have both legal and clinical capacity before being allowed to leave against medical advice.

If a patient does not have decision-making capacity and chooses a course of action that may be potentially harmful, it is usually best to proceed with treatment that is in the patient's best interests. Consulting hospital legal counsel or a psychiatrist to determine whether a patient has capacity also may be of benefit.

Informed refusal

A competent patient may make a decision against his or her interests, but first must be presented with information sufficient to make an *informed* decision. The information provided should be accurate, and in general should include that which a reasonable layperson would want to know in addition to any other information the patient reasonably requests.

The failure to disclose sufficient information to patients who leave AMA is the subject of most litigation regarding AMA discharges.

In *Landon v. Zorn*, 884 A.2d 142 (2005), a patient sought care in the ED for "flu-like symptoms" and leg pain. The physician wanted to perform a CT scan of the patient's leg, but the patient refused and was eventually discharged home. While the physician testified that the discharge was "against medical advice," no AMA form was completed pursuant to hospital policy. Twelve hours after being discharged, the patient returned to the hospital and was diagnosed with necrotizing fasciitis that required an amputation of the patient's entire leg.

During the subsequent trial, the jury determined that the physician was not negligent. The patient appealed the verdict, in part alleging lack of informed consent, stating that the physician did not explain the full extent of the risks the patient could face by not having the CAT scan done. While the Maryland Supreme Court decided in favor of the physician, it hinted that the outcome may have been different had the patient presented expert witness testimony that the physician should have discussed the risks and benefits of refusing the CT scan.

Sawyer v. Comerci, 2002 VA 411 (2002), involved a patient with right

sided abdominal pain, an elevated WBC count, and blood in his stool. The emergency physician wanted to admit the patient, but the patient had a business appointment the following day and refused to be admitted. The emergency physician still believed that the patient required admission, but her notes stated that the patient and his wife "do not seem to understand the possibility of the seriousness of his condition." After the patient's primary care physician agreed to see the patient either the next morning or the following Monday, the patient was discharged. No AMA form was signed.

Several days later, the patient returned to the hospital by ambulance with dyspnea and diaphoresis. He was admitted, but died the following day. He had never attempted to make a follow-up appointment with his primary care physician.

The case was decided in the physician's favor at trial, but was appealed. One of the issues on appeal was whether the patient was contributorily negligent for leaving the hospital on the first ED visit. The Virginia Supreme Court noted that the emergency physician never noted in the patient's medical chart that the patient should have been admitted to the hospital on the first visit. In addition, the emergency physician presented no evidence that the patient "understood the severity of his condition and the consequences that might ensue if he were not admitted ... to the hospital." Because the patient was not provided with sufficient information, he could not be held responsible for his decision to leave against medical advice. Incidentally, the Supreme Court did hold that the patient's failure to make follow-up appointments may be used as evidence that he did not "mitigate" his injuries.

In *Taylor v. Steinberg*, 2002 OH 2928 (2002), a surgeon performed a cholecystectomy on a patient. Postoperatively, the patient developed a bile leak that went undiagnosed despite much diagnostic testing. The surgeon wanted either to repeat an ERCP (endoscopic retrograde cholangiopancreatography) in a week or to perform an immediate reoperation, stating that he believed a bile duct leak was present. The patient became angry that no definitive diagnosis had been made and wanted to leave the hospital. No AMA forms were signed and the discharge papers said that the principle diagnosis was "abdominal wall hematoma." The patient was later admitted to another institution where five liters of bile were drained from his abdomen. He eventually died.

In the ensuing litigation, the surgeon alleged that the patient left AMA and was, therefore, responsible for his own injuries. A verdict of $1.2 million was entered against the surgeon. The Ohio Appellate Court noted that the surgeon showed no evidence that he informed the patient of the seriousness of his condition. The surgeon's notes showed no "reservations" about the patient leaving the hospital. In addition, no AMA form was completed and the absence of an AMA form "undercut [the surgeon's] claim that he recognized the seriousness of [the patient's] situation" and "created the inference that [the patient] was not informed of the seriousness of his condition such that his decisions about his own care were fully informed." The verdict was upheld.

Mueller v. Auker, 04-399-S-BLW,[4] is a 2007 Idaho Federal Court decision holding that an emergency physician may be liable for exaggerating the risks involved with refusing care. A 5-week-old child was brought to the emergency department with a 100.8° F fever. After examining the child, the emergency physician believed that a spinal tap and intravenous antibiotics were necessary. The mother refused. The physician explained the risks of refusing such treatment, but whether he cited a 5% risk of *death* or a 5% risk of *meningitis* is a disputed fact. After the mother's repeated refusal of further treatment, a social worker declared the child in "imminent danger." The State took custody of the child and the physician performed a spinal tap which showed no signs of meningitis. The child was returned to the custody of her parents the following day.

The child's parents then sued multiple parties, including the physician, whom they accused of conspiracy to deprive the family of their constitutional rights by grossly inflating the risk of refusing treatment in order to get the State to take custody of the child. While Idaho statutes provided immunity for physicians who report suspected child neglect or abuse, the Federal Court noted that if the physician knowingly exaggerated the risk of danger to the child, the statutory immunity would not apply and the physician could be held liable. The Court held that some of the defendants had violated the constitutional rights of the family as a matter of law and set the remaining issues, including the physician's liability, for jury trial.

How do physicians protect themselves?

1. Many patients leave AMA for reasons unrelated to their medical care. Address patient concerns if possible. For example, if a patient is unable to afford treatment, reiterate that finances are not taken into consideration for emergency care and offer to have the patient meet with a hospital financial counselor to make payment arrangements if they need hospitalization. If the patient doesn't have someone to take care of their animal at home, offer to call a neighbor or family member. If the patient feels well enough to leave, help the patient understand why allowing the proposed treatment is in their best

interests. Inform them of the possible risks, even if they feel well. Give the patient articles to read if available. Document your attempts to mitigate the patient's circumstances.

2. According to one British study, many physicians could protect themselves by better documenting the AMA interaction.[5] In this study, *half* of "self discharge" patients were under the influence of drugs or alcohol (raising issues as to their decision-making capacity). Prior to study intervention, *none* of the charts documented the patient's decision-making capacity and only 58% of the charts contained a signed AMA form.

3. A signed AMA form isn't essential, but it creates a "rebuttable presumption" that the patient was presented with and understood the information contained on the form. The patient must then present evidence to overcome the presumption that refusal of care was an informed refusal. If a patient refuses to sign an AMA form, the physician should note the interaction on the chart, and may even want to include a copy of the unsigned AMA form that was presented to the patient.

4. Give the patient the same medical care you would give any other patient with the same condition. It would be hard to defend a decision not to renew a patient's albuterol inhaler and prednisone if the patient left AMA and later died from an asthma attack. While discussing the case of *Drummond v. Buckley,* 627 So. 2d 264 (1993), the Mississippi Supreme Court stated that "Surely, it cannot be suggested that supposed medical professionals would withhold proper service because a patient ... exercised his prerogative not to follow medical advice."

Conclusion

When patients refuse medical treatment, both the potential for bad outcomes and the potential for a liability increase. Taking the extra few minutes to communicate the implication of a decision to leave AMA with the patient and fully documenting your discussions may save the patient's life and also may save you many years in court trying to defend a lawsuit. ■

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Continued from page 65

care delivery, says **Pamela S. Rowse-Schmidt**, RN, quality/risk consultant and former ED manager at St. Rose Dominican Hospitals-Rose de Lima Campus in Henderson, NV.

Rowse-Schmidt gives a hypothetical example of a patient admitted from the ED as a rule-out acute coronary syndrome, with the first troponin level coming back negative. The patient is held for an admission to a medical/telemetry bed. While the patient is still in the ED, the next troponin level comes back critically elevated. "If it's a different shift, who communicated that very valuable information to the current caregiver? Probably no one," says Rowse-Schmidt.

After being admitted to the medical/telemetry bed, the patient's condition deteriorates and it becomes clear that patient is having an evolving myocardial infarction. As a result, the patient is transferred to the ICU in an emergent condition.

The delay in admitting to the appropriate level of care, based on the critical lab value, has the potential for resulting in additional myocardial damage and ultimately extending the patient's length of stay, as well as resulting in a further diminished cardiac functioning. "In this case, delay in identifying a potentially life threatening event could result in death," she says.

Particularly if the patient died, or suffered long-term affects from the event, the family would have a case for litigation, says Rowse-Schmidt.

Here are risk reduction strategies for change of shift:

- Have the oncoming physician sign the chart of all patients being turned over to them. "This will often have the effect of making the oncoming physician more diligent in following up on results and rechecking the patient," says Counselman. "The patient is now 'theirs' without question."
- Have the oncoming physician examine all patients turned over to them, except for the most benign cases such as those waiting for a single, simple laboratory test, and write a brief note on their chart. "This gives the oncoming physician the opportunity to form their own impression of the patient, and also allows the patient to know who their doctor is in case they have questions," says Counselman.

This is much better than having a patient who has been in the ED for several hours and wants to talk to their physician to be told "your doctor has gone home," he says.

At George Washington University Hospital in Washington, DC, change of shift is viewed as "an opportunity rather than a risk," says **Robert Shesser**, MD, professor and chair of the department of emergency medicine. The physician leaving reviews all patients with the second physician who is coming on shift who asks the "hard" questions. "They generally ask the physician to explain any lab abnormalities that are already identified, what labs or X-rays have been sent and have not yet returned, and what the plan would be depending on what is found," he says.

Make every effort to have physician and nurse shift changes occur at different times, not the same time.

Schedule the physician going off service one additional paid hour to stay in the ED and help with the transition. "We also schedule our senior resident shifts to overlap the attending shifts so there is some continuity of care for the critical patients," says Shesser.

Some EDs have a culture of not signing out patients, which means that a physician going off service stops seeing new patients some amount of time before shift change. "Our culture has always been to see new patients right up until the last minute and feel free to check them out," says Shesser. The new physician always goes to see patients who have been checked out to them, so the patient gets two evaluations versus one. "I think over time, we have caught more problems with this approach than had things slip between the cracks because there was checkout," says Shesser.

Use an electronic medical record (EMR). Since an EMR is used at George Washington University's ED, there is very little chance of any key information getting lost, because the record is the repository for all information developed during the previous shift. "All lab and X-ray data are in one place and color coded according to whether it is normal or abnormal," says Shesser. ■

LWBS patients: Tremendous risk potential for ED staff

Many EDs lack records, documentation, or statistics

by Stacey Kusterbeck, Contributing Editor

The number of ED patients who leave without being seen (LWBS) has increased from 1.1 million in 1995 to 2.1 million in 2002, and also, vulnerable populations such as younger, Hispanic, and uninsured patients are at higher risk, says a new study.[1]

"Although our study did not examine the root causes of LWBS, it is likely that LWBS is linked to the larger national problem of ED overcrowding," says **Benjamin C. Sun**, MD, the study's lead author and assistant professor of medicine at University of California-Los Angeles. "There is much research on this topic, but major contributors to ED crowding include lack of inpatient bed capacity and increasing volume and complexity of ED visits."[2,3]

Several studies suggest that a significant percentage of LWBS patients have acute illness and require urgent medical evaluation or hospitalization, Sun notes.[4,5] "Many institutions use the ED LWBS rate as a quality metric," he says.

Since LWBS rates are strongly related to wait times, reducing the number of inpatient 'boarders' in the ED, increasing staff, and creating 'fast track' services also may reduce LWBS rates," says Sun.

From a legal perspective, LWBS patients are one of the "high risk" patient groups in the ED, 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. "These are patients who can potentially leave the facility, suffer adverse outcomes, and seek to blame it on the hospital or nursing staff for 'constructive abandonment' or some other theory," he says.

Since the patient left without completing assessment and care, the hospital often lacks even basic records and data to defend such a case, notes Frew.

Sources

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EMTALA implications

In addition to fines and penalties issued by Centers for Medicare & Medicaid (CMS), it is not uncommon for plaintiffs in medical professional liability claims to allege violations of the Emergency Medical Treatment and Labor Act (EMTALA), says **Christy Tosh Crider**, a health care attorney at the Nashville, TN, office of Baker, Donelson, Bearman, Caldwell & Berkowitz. "Although patients cannot sue physicians for EMTALA violations, evidence of these violations can inflame jurors in professional liability cases against physicians and hospitals," says Crider.

Before EMTALA was enacted in 1986, many states did not recognize any hospital liability for patients who left voluntarily without receiving treatment. "EMTALA created a cause of action that might support these claims," says Frew.

Under the current EMTALA law, and many state laws that followed EMTALA, a patient may still leave before being treated without creating liability, but the standards for hospital duties have been increased. Frequently, the LWBS patient is the source of CMS citations for EMTALA violations, and for cases with serious adverse outcomes, EMTALA lawsuits may result, says Frew.

On November 10, 1999, a Special Advisory Bulletin from CMS and the Department of Health and Human Services' Office of the Inspector General clarified the EMTALA obligation for an individual who leaves without notifying the hospital. According to the bulletin, staff should document the fact that the person had been there, document what time the hospital discovered that the patient left, and retain all triage notes and additional records, if any.

The CMS standards require that if the hospital or its employees are aware that the patient intends to leave, a written refusal of services must be obtained from the patient. The refusal must list the dangers of leaving without completion of medical assessment and care and the benefits of staying.

"If the patient refuses to sign the form, the hospital must document the reasonable efforts it made to obtain the refusal," says Frew. One of the common errors that ED staff make, however, is to simply take the verbal statement that the patient is leaving and move on to the next patient.

Don't discard records

ED staff often fail to log the LWBS patient, discard the triage sheet or other records that were started, and fail to record any details of the statements made upon the patient's departure. "These common errors set the hospital up for multiple EMTALA violations if CMS becomes aware of the visit and investigates," Frew warns.

For scenarios like this, EDs have been cited for failure to log, "financial" issues such as the patient's perception that they are waiting for insurance approval or belonging to the "wrong" plan, failure to obtain a written refusal, failure to maintain medical records on the patient, and failure to triage the patient in a reasonable time. In some cases, EDs have been cited for "constructive" denial of a medical screening examination (MSE), which means that the patient was left without assessment and care for so long that it was the practical equivalent of denying care.

Although CMS does not have fixed guidelines for wait times, investigators will expect that the patient in the waiting area was reassessed periodically at a frequency appropriate to their presenting complaint or condition, and that these reassessments were documented in the record.

"Citation thresholds in cases I have dealt with range from an incident of a delay in triage for seven minutes with a patient who cannot breathe, to citations where patients with minor conditions have waited for 13 hours before giving up and leaving," says Frew.

In most citations, elapsed times before the patient leaves typically are within the first hour if there has been no triage, and over two hours after triage, says Frew. "In reality, I seldom see reassessments documented in ED records, leaving most of these LWBS cases as prime risks for EMTALA citations," he says.

Very few EDs have systems in place to obtain written refusals from LWBS patients or document the incident, and staff often seem surprised to learn that there are regulations for LWBS situations, adds Frew.

Frew says that LWBS situations become EMTALA investigations and possibly lawsuits when:

- The patient goes elsewhere and complains that they were denied care at the first hospital, and the second hospital is obligated to report a possible EMTALA violation at the first hospital.
- The patient has an adverse outcome, turns up at another hospital, and the second hospital is obligated to report a possible EMTALA violation at the first hospital.
- The patient has an adverse outcome and sees a lawyer, who reports a violation to CMS to get a free investigation that may support a lawsuit. The angry patient calls in a complaint themself.
- Inspectors catch the incident when they routinely pull LWBS cases for review during site visits.

"With over 2 million reported LWBS patients per year in 2002, I would personally estimate that the unreported LWBS rate is at least that large as well," says Frew. "This amounts to 4 million opportunities for EMTALA violations on the LWBS issue alone." He estimates that at least 25% of those cases could be cited by CMS for clear violations of EMTALA requirements if they were reviewed. "That is a tremendous risk potential," says Frew.

In addition, many EDs don't have reliable figures on

their LWBS rates or the timeframes involved. "Many hospitals I visit cannot provide data on their LWBS rate," says Frew. "Those that can seem to have widely different LWBS rates that do not necessarily correlate to ED size, hospital capabilities, or number of patients presenting."

To ensure EMTALA compliance for LWBS patients, your ED should have policies and procedures in place for the following, says Frew:

- Logging and documenting all LWBS patients.
- Obtaining written refusal forms and documenting attempts to obtain signatures.
- Documenting that patients were called when they left the ED without informing the staff, with specified standards for when LWBS situations justify a telephone follow-up.
- Reassessing patients in the waiting areas at regular intervals.

In addition to these EMTALA compliance requirements, LWBS cases should be automatic quality review triggers. They should be evaluated within 24 hours by ED managers, looking for all the required documentation, with up-to-date tracking and trending done. "Documentation errors should be addressed promptly. Trends should be addressed as soon as they become evident," says Frew.

However, the conditions of overcrowding that cause the LWBS situations also tend to prevent real-time quality reviews, notes Frew. "LWBS then tend to be viewed almost as a blessing—one less patient to see," he says. "Nothing is done to address the situation until a catastrophic outcome or EMTALA citation shocks the department back to reality."

Sources

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Avoid liability

Your ED can avoid liability if it is documented that the LWBS patient was logged in, triaged, and that the MSE was not delayed within the capability of the staff, says **Danielle Trostorff**, shareholder in the health care department of the New Orleans office of Baker, Donelson, Bearman, Caldwell & Berkowitz. The delay must be related to the priority of cases treated within the ED and not on the basis of any discrimination such as diagnosis, financial status, race, color, nationality, or handicap. "The delay must not be part of a routine practice of the hospital to discourage patient treatment without justification," she says.

According to the CMS Interpretative Guidelines, if an individual leaves the ED against medical advice, or leaves without being treated of his or her own free will, with no coercion or suggestion, the hospital is not in violation of EMTALA.

If the patient notifies staff of their intention to leave before receiving an appropriate MSE, your ED should document its intention to provide the patient an MSE. Also document attempts made to provide the individual with an informed consent of the risks of refusing a medical screening and appropriate treatment, if necessary.

When investigating a LWBS case, CMS will look for an informed refusal of examination and treatment form, signed by either the patient or a person acting on the patient's behalf, or documentation stating that the patient refused to sign the form.

The investigator, or a court in the case of a private action, also will look for documentation that the hospital staff attempted to explain the risks of refusing treatment. "The ED physician must adequately document the risks of refusing treatment, to the extent he or she had an opportunity to speak with the individual," says Trostorff.

Remember that the ED is literally the front door to the hospital, says Frew. "The two most likely patients to walk out of your ED due to delay are the paying patient and the irate patient," he says. "Both of these patients can hurt the hospital by their departure." ■

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CNE/CME *Questions*

23. During change of shift in the ED, which of the following is recommended?
    A. Have physicians and nurses change shift at the same time.
    B. Avoid having oncoming physicians examine patients unless requested by the offgoing physician.
    C. Have the oncoming physician sign the chart of all patients being turned over to them.
    D. Avoid using an electronic medical record.

24. Which of the following is recommended to reduce risks of patients who leave without being seen?
    A. Discard triage logs.
    B. Avoid documenting specific statements made by patients.
    C. Don't require patients to sign written refusals.
    D. If a patient won't sign a refusal form, document that an attempt was made.

25. Which of the following is a potential violation of the Emergency Medical Treatment and Labor Act?
    A. ED staff fail to obtain a written refusal when a patient informs the triage nurse they are leaving.
    B. The patient is left waiting for so long that it is the practical equivalent of denial of care.
    C. No medical records are maintained for a patient who leaves the ED without care.
    D. All of the above.

26. How would recent court decisions concerning admissibility of incident reports in civil litigation be better managed?
    A. Eliminate the use of incident reports because the practice is an anachronism and rarely useful.
    B. Bifurcate the collection of "incident reports" from information and data collected in "anticipation of litigation".
    C. Establish a "patient safety evaluation system" and create or affiliate with a "patient safety organization" (PSO).
    D. All of the above.

Answers: 23. C; 24. D; 25. D; 26. D

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. ■

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. ■