ED Legal Letter™

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IN THIS ISSUE

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Liability of physicians who fail to fulfill on-call responsibilities to the ED

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

The diminishing availability of on-call specialists willing to provide emergency services has been well documented.[1-4] Emergency physicians (EPs) are particularly, painfully, and acutely aware of the problem since countless precious hours are spent seeking care or arranging transfers for patients needing specialty intervention. Two recent cases address the liability of neurosurgeons (NSG) who agreed to be on-call but failed to be available when needed or outright refused to come to the emergency department (ED) to treat an emergency patient when called.

Brown v. Greg Bailey, MD[5]

A 69-year-old woman was admitted via the ED to Forest Park Hospital in Missouri with pneumonia. Shortly after admission, she tried to get out of bed but became tangled in the IV tubing. She fell and struck her head, lacerating an eyebrow. An intern sutured the laceration, and because the patient appeared confused the intern returned every 15-30 minutes to reexamine the patient. About an hour after the fall, out of concern for the patient's mental status (and the fact that she was taking the blood thinner Coumadin [warfarin-sodium]), the intern ordered a head CT scan. After another 2 hours, the CT scan interpretation revealed an epidural hematoma and some subarachnoid blood. The intern discussed the case with the supervising resident; then called the patient's attending ("to get permission to call a neurosurgeon"); and finally paged Dr. Bailey, the NSG on-call for the hospital.

Dr. Bailey had arranged for one of his partners, Dr. Wetherington, to cover call for him. However, he failed to inform the hospital of the change, despite that the on-call schedule required him to notify the medical staff office of any changes. More problematic though, and known to Dr. Bailey, was that Dr. Wetherington did not have privileges to practice NSG at that hospital. Thus, the physician actually on-call lacked privileges to treat neurosurgical cases there.

Fortunately, Dr. Wetherington answered the page for Dr. Bailey. Unfortunately, he informed the intern of his inability to treat patients there and instructed the intern to transfer the patient to a hospital where he did have privileges or to the nearby university hospital. Five hours passed between the time the CT results were known and the patient was actually received in transfer at the university, during which time the court pointedly noted the patient "continued to bleed on her brain while await-

ing transfer" and ultimately died.

Subsequently, the family filed a wrongful death action against Dr. Bailey, the intern, the resident, the patient's admitting physician, Dr. Wetherington, and the hospital. The hospital settled the case and the doctors in training were dismissed. The family proceeded to trial against the remaining defendants and the jury awarded damages in the amount of $400,800, assessing 50% of the fault to Dr. Bailey.[5]

Dr. Bailey appealed, arguing that he could not be held liable for damages to the patient because he had no duty to the patient, since no physician-patient relationship had ever been established.[5]

The plaintiffs countered that: 1) Dr. Bailey did owe the patient a duty of care, by virtue of being on-call for the hospital; 2) Dr. Bailey had a duty to provide reasonable notice to the hospital that he would be unavailable to respond to calls; and 3) he had a duty to refrain from delegating his on-call duties to a NSG without the requisite privileges to treat patients at that hospital.[5]

The Appellate Court's Decision. The court agreed that no physician-patient relationship between Dr. Bailey and the patient ever existed; therefore, the plaintiffs could not sue the neurosurgeon for *medical* negligence.[5,6] Under Missouri law, a physician's duty of care to a patient is derived from the physician-patient relationship.[6,7] No relationship means no duty and no viable malpractice claim. (Remarkably, plaintiff's counsel never argued that federal law [EMTALA] may impose a duty upon an on-call physician to come in to treat patients with emergency conditions.)

However, the court distinguished a claim for damages against a physician based on *"medical"* negligence from a claim based on *"general"* negligence. First, under medical negligence a physician's negligent acts or omissions involve a matter of medical science, whereas in a claim for general negligence they do not. Second, in a medical negligence claim the source of the physician's duty to the patient is the existence of a physician-patient relationship; for a claim on general negligence a physician's duty may exist as a matter of public policy, without the requirement of a physician-patient relationship.

In determining whether public policy supported imposing a legal duty on Dr. Bailey, the court applied three factors:[8] 1)the economic burden upon the physician and the community; 2) the prevention of future harm; and 3) the foreseeability of harm.

The court quoted its own precedent from a famous on-call case of the late 1990s, *Millard v. Corrado*.[6] For the first factor, the court stated that "imposing a duty on 'on-call' physicians to notify appropriate hospital personnel of their unavailability does not place an unreasonable burden on the medical profession." Pertaining to the second factor, the court held that "if such a duty is imposed on 'on-call' physicians, there would be a reduced chance that similar incidents would occur in the future." Finally, with respect to the third factor, the court found that the risk of harm to which a patient was exposed due to Dr. Bailey's failure to notify the hospital of his unavailability was reasonably foreseeable.

Evidence supporting the court's conclusion that the harm to an emergency patient, such as a member of the Brown family, was particularly foreseeable included:

1. Dr. Bailey knew the hospital would not have NSG coverage in his absence.
2. Dr. Bailey knew that delegation of his on-call responsibilities was "conclusively ineffective" because Dr. Wetherington did not have privileges to perform NSG surgery at that hospital;
3. Dr. Bailey was also aware that, as a result of his actions, the hospital would have to transfer any patient with a neurosurgical emergency regardless of the patient's physical condition or the delay associated with the transfer; and
4. Dr. Bailey's failure to notify the hospital of his

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Senior Vice President/Publisher: Brenda Mooney
Associate Publisher: Lee Landenberger
Senior Managing Editor: Suzanne Thatcher
Contributing Editors: Robert Bitterman, MD, JD, FACEP, Stacey Kusterbeck, Bruce Janiak, MD, FACEP, FAAP.

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Questions & Comments

Please contact **Suzanne Thatcher,** Senior Managing Editor, at suzanne.thatcher@ahcmedia.com or (404) 262-5514.

unavailability created a false sense of security that a neurosurgeon would be available on-call to care for emergency patients within a reasonable time.[5]

Therefore, the court concluded, as it had done in *Millard v Corrado*,[6] that under a *general* negligence claim:

- "On-call" physicians owe a duty to reasonably foreseeable emergency patients to provide reasonable notice to appropriate hospital personnel when they will be unavailable to respond to calls; and
- Physicians who cannot fulfill their "on-call" responsibilities must provide notice as soon as is practicable once they learn of circumstances that will render them unavailable.[5]

The appellate court affirmed the damages award against Dr. Bailey.

Seeber v. John Ebeling, MD[9]

After sustaining injuries in a motor vehicle crash, Mr. Seeber was taken from the scene via helicopter to the St. Francis Regional Medical Center ED in Topeka, Kansas. The EP diagnosed a C7 fracture with an incomplete spinal cord injury and then contacted the NSG on-call, Dr. Ebeling, around 8 p.m. to come to the ED to examine and treat Mr. Seeber. Dr. Ebeling twice refused to come to the ED, claiming he was "very fatigued." He told the EP to transfer the patient to the University of Kansas Medical Center, about 65 miles away. The patient eventually was transferred and underwent surgery the next day; the patient's end result was complete paraplegia.

Mr. Seeber sued Dr. Ebeling for negligence. The trial judge, however, dismissed the case. The judge held as a matter of law that because Dr. Ebeling refused to accept Mr. Seeber as a patient no physician-patient relationship was created between Ebeling and Seeber; therefore, Mr. Seeber was unable to establish the duty element of his negligence claim necessary to proceed to a jury trial.[9]

Under settled Kansas law, just like in Missouri and other states, a duty of care (which is required to sue a physician for medical negligence) is premised on the existence of a physician-patient relationship.[10]

Mr. Seeber appealed, presenting essentially the same arguments as the plaintiffs in *Brown v. Bailey*.[5,9] First, he noted that being the NSG on-call for the ED creates a duty of care to a patient who presents with a neurosurgical emergency. Second, he argued that independent of the duty that flows from a physician-patient relationship, and again based on "public policy" or "*general*" negligence considerations, there should be a duty on the part of an on-call physician to notify appropriate hospital personnel whenever he or she is unavailable to treat patients with emergency conditions.[9,11]

The Appellate Court's Opinion. The court rejected Mr. Seeber's first contention, stating that a physician-patient relationship is consensual and the mere fact that a physician has agreed to be on-call does not establish a consensual relationship. Instead, the physician must expressly agree to accept a patient or take some affirmative action to advise or treat the patient for the relationship to be established.[9,12]

In this case, it was undisputed that Dr. Ebeling refused to accept Mr. Seeber as his patient and that Dr. Ebeling never offered any medical advice or directed the course of the patient's treatment in the ED. Instead, he immediately told the EP he was too tired and refused to treat Mr. Seeber.

According to Dr. Ebeling, he made a "judgment call that Mr. Seeber would be better off at a trauma center that had a trauma team and a fresher surgeon."[9] (The court never explored whether the trauma center really did have a "fresher" surgeon or exactly how Dr. Ebeling knew if that was true at 8 p.m. on the night in question.) He testified that he was "feeling run-down because he had been an on-call physician every third night for more than 10 years."[9] It was the only time Dr. Ebeling could remember being too fatigued to attend to a patient when he was on-call (which was confirmed by the EP).

Dr. Ebeling testified that "on-call" meant that he was available for *consultation*, not that he was required to come to the hospital and treat a patient with a neurosurgical emergency.[9] Curiously, no evidence concerning medical staff or hospital rules delineating the duties or responsibilities of the hospital's on-call physicians was presented in the appeal. Dr. Ebeling asserted that it was just "customary" that he would take call every third day and be available to consult with physicians in the EDs at St. Francis and the other hospital in town concerning patients with neurosurgical conditions. (There were only three neurosurgeons in Topeka available to take call.)

The court held since Dr. Ebeling was available for consultation on the evening in question, responded within a reasonable time, and provided "consultation," the uncontroverted evidence established that Dr. Ebeling fulfilled his on-call duties.

Mr. Seeber's second argument, that the public policy of Kansas should recognize an independent duty on the part of an on-call physician to notify appropriate hospital personnel of his unavailability, also failed in this case.[9,10] To support his assertion, Mr. Seeber presented the same arguments as the plaintiff's in Brown, and also cited as support the *Millard v. Corrado* case.[6] However, the court rejected all of Mr. Seeber's arguments, citing case precedent in Kansas,[13-15] and distinguished Dr. Ebeling's case from the *Millard* case[6] for the following reasons:

1. Dr. Ebeling did not sign up to be on-call. Rather, his on-call status arose by "custom" because he was one of only three neurosurgeons in Topeka. Also, when Dr. Ebeling was on-call, he was also on-call for two

hospitals in Topeka. Furthermore, Dr. Ebeling actually responded to the EPs call within a reasonable time, discussed the case, and then informed the EP of his fatigue. In *Millard,* the on-call physician was out of town and could not possibly come to the hospital to treat a patient.

2. There was no evidence that when on-call Dr. Ebeling was required to come to the hospital and treat a patient; rather, being on-call meant that Dr. Ebeling had a duty to be available for consultation only. Dr. Ebeling did not have a contract regarding call with the hospital.
3. When Mr. Seeber suggested that Dr. Ebeling had a duty to inform the hospital that he was too fatigued to come in to the hospital that evening, the court accepted Dr. Ebeling's counter argument that it is not reasonably foreseeable for a surgeon to know whether he or she will want to or be able to accept a patient without first learning about the patient's condition. For example, there is an enormous difference between treating a person with a peripheral nerve injury as opposed to treating the type of injuries sustained by Mr. Seeber.
4. Missouri's legislature passed a law — two years *after* the Millard incident — which required on-call EPs to arrive at the hospital within 30 minutes of being contacted.[16] The Seeber court stated that this regulation supports a public policy recognition of a duty in Missouri because it "evidences a social consensus to ensure that emergency room physicians attend to their patients within a reasonable time." The Kansas court found no such "social consensus" existed in Kansas.
5. The court noted another important distinction between *Millard* and Mr. Seeber's public policy assertions: Seeber had not pointed to any regulation, law, or policy which would establish such a "social consensus" in Kansas that on-call physicians must actually come to the hospital to treat patients with emergencies. The court said to impose such a duty upon a physician who is on-call "would have a chilling effect on the profession. Physicians would not want to volunteer to receive calls from hospitals if a physician could be required to come into the hospital and treat a patient even though the physician did not feel competent to handle a particular case."[9]

In the end, the Mr. Seeber's "public policy" argument failed when the court rejected the logical rationale put forth in the *Millard* case. The Kansas appellate court held that Dr. Ebeling was not liable for failing to inform the ED of his unavailability to handle NSG emergencies and no liability for refusing to come to the ED when called.[9]

Comment

The court's peculiar opinion in *Seeber v. Ebeling* transposes the reader back to the late 1970s and early 1980s, before Congress passed EMTALA precisely to remedy the problem of hospital EDs not knowing, *prospectively*, whether they did or did not have particular on-call specialty coverage on any given night.

It is certainly understandable that neurosurgeons fatigue and occasionally simply can't take on another case. They are too short in numbers but critically needed, and work ungodly hours. However, it is wholly unacceptable when they fail to inform the ED of their unavailability.

First, EMS may be diverted so that critically injured neurosurgical patients can be taken directly to a facility with the capability to handle the emergency instead of wasting time (to the patient's detriment) reaching, negotiating, cajoling, begging, or otherwise engaging the NSG on-call and then losing still more time arranging transfers. In *Seeber*, the patient was airlifted from the scene and could have been diverted directly to the University hospital had the EP known his NSG was incapacitated.[9] But for a simple considerate phone call, the patient lost 5-6 hours in reaching definitive care. Such delay doesn't always make a difference. It probably did not in this case, but certainly sometimes it really makes a life or death difference.

Second, even if a patient with a neurosurgical emergency presents directly to the ED without involvement of EMS, if the EP knows the NSG is unavailable he can immediately initiate the transfer instead of processing through the time-wasting phone calls/negotiating dance with the allegedly on-call NSG. Similarly, accepting hospitals are much more reticent to accept patients if the hospital has a NSG listed as "available" on its call schedule. This is particularly true if the listed on-call NSG declines to come in and care for the patient for whatever reason, but especially for vague "fatigue" reasons. The transfer is much easier to effect if the EP can forthrightly say, in advance of the patient's presentation, that his NSG informed him he was unavailable.

Third, it is somewhat specious to argue that one needs to learn of the case before deciding if one is too fatigued to handle it. *Anytime* a NSG feels unable to handle the next major case through the door he should promptly inform the EP on duty. The two physicians can discuss the situation and mutually consider options, but at least this way the EP knows where the department stands *before* the next critically injured patient enters the system and can react accordingly.

Every hospital must have *written* policies and procedures defining exactly what it means to be "on-call" at that facility. Specifically:

1. Is the on-call physician available only to "consult," or expected to come to the ED when necessary to examine and stabilize patients with emergency conditions? (Under EMTALA, the hospital should con-

tractually or through the medical staff by-laws require on-call physicians to present to the ED to help screen or stabilize emergency patients.)[17]

2. Is the on-call physician required to respond to in-house emergencies when requested by the patient's admitting physician, or is he only required to respond to emergencies presenting to the hospital's ED? (Dr. Bailey argued he was only on-call for the ED; therefore, he didn't have to respond emergencies that arose in inpatients. Under the hospital's practice, being on-call for the ED included in-house emergencies, so this defense failed. The case also occurred before the government ceased applying EMTALA to inpatients.)[18] Everyone at the hospital needs to know the answer in advance.
3. The on-call physician must respond within a "reasonable time." Under federal law the hospital must place in writing the response time "in minutes."[19] Using the word "reasonable" in the written medical staff rules and regulations is no longer acceptable.[19] Some states, such as Missouri, do require the on-call physician to respond within a specified time frame, typically 30 minutes.[16]
4. Require the physicians to notify the hospital or the ED promptly if they become unable to respond when on-call for the hospital.
5. Create and implement a written plan defining the actions the ED should take if the on-call physician is unavailable or refuses to come to the ED when requested. What chain of command does the EP follow?
6. Monitor the on-call system and the response of the on-call physicians. Every hospital knows its problem players; the hospital should act to correct the physician's behavior before it costs a patient his or her life, and the hospital some bad publicity, a government investigation, and of course civil litigation.

Finally, the Missouri court's conclusion in both Brown and Millard sums up what EPs, hospitals, and the community at large justifiably expect of physicians on-call:

- Physicians who cannot fulfill their "on-call" responsibilities must provide notice as soon as practicable once they learn of circumstances that will render them unavailable.[5] ■

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14. E.g., *Dawson v. Prager*, 76 P.3d 1036 (Kan. 2003).
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16. MO. 19 C.S.R.30-20.021.
17. 42 U.S.C. Section 1395cc(a)(1)(I): "in the case of a hospital or rural primary care hospital ... (iii) to maintain a list of physicians who are on call for duty after the initial examination *to provide treatment* necessary to stabilize an individual with an emergency medical condition." Emphasis added.
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What are liability risks when patients don't speak English?

Know your obligations under the law
by Stacey Kusterbeck, Contributing Editor

Imagine yourself at 2 a.m. trying to determine if a patient clutching his chest is having a myocardial infarction, but this patient doesn't speak a word of English. Would you use a Spanish-speaking housekeeper to translate or call a nurse away from her duties in the intensive care unit?

Both of these options are legally risky, says **Val Warhaft,** MD, chief medical officer of Emergent Medical Associates, an organization that manages the emergency departments of several hospitals in southern California. "They are fraught with potential bias, violation of patient confidentiality, and ultimately, risk, if things don't go well."

EDs nationwide are caring for increasing numbers of non-English speaking patients and patients with limited English proficiency (LEP). There is no question that these patients present significant liability risks. "As an ED physician, having someone with whom I cannot

—continued on page 80

SPECIAL REPORT

Medical-legal consulting pearls from an experienced expert witness

Editors Note: Bruce David Janiak, *MD, FACEP, FAAP, vice chairman and professor of emergency medicine at the Medical College of Georgia in Augusta has been involved in medical-legal consulting for nearly 30 years. He also holds the distinction of being the very first emergency medicine residency graduate in the world.*

Executive Editor: Dr. Janiak, how and when did you get started doing medical-legal reviews?

Dr. Janiak: I began reviewing medical legal cases in the mid-to-late 1970s when asked by a local attorney. Since then I have reviewed about 900 files, some for insurance companies, but most for attorneys on both sides. After 30 years, I have learned a lot (often by making a mistake).

Executive Editor: You remain very active as a clinician and teacher of emergency medicine residents. How has this medical-legal work affected your clinical practice?

Dr. Janiak: There is no doubt that my practice of emergency medicine has improved by learning from the errors of others. Furthermore, being part of a residency program allows me to share some of the things I have learned as a result of being an expert witness.

Executive Editor: What advice do you have for the physician who has decided to become an expert witness? How does a physician interested in medical-legal work get started?

Dr. Janiak: The process will usually begin with a phone call or letter, asking if you would be interested in reviewing a case. In most cases, it will be obvious as to whether the attorney is representing a doctor or a patient. When first accepting a case, ask for the names of the doctors and/or hospitals involved so that you can determine if you have a conflict of interest. There is no use spending a lot of your time reading only to find out that the defendant physician is an old friend of yours. If so, you have a conflict of interest that must be disclosed. If you have to turn down the review, it helps to offer the name of another qualified expert to the requesting attorney. He or she will especially appreciate your willingness to refer.

Executive Editor: What generally happens next?

Dr. Janiak: Attorneys will often send the medical records along with a summary of the case. I recommend that you do not read the summary. At discovery you will be asked to bring all documents to your deposition. Be prepared to respond when asked, "Did you rely on your attorney's summary to formulate your opinions"? I prefer to answer that I did not read the summary, but relied on my own interpretation of the materials provided. The jury may appreciate that your opinions are your own and were formulated from your own objective, independent review.

Executive Editor: What other steps do you take to try and remain objective?

Dr. Janiak: Try to review all of the emergency records before you know the outcome of the case. Initial contact with an attorney is usually by telephone and he or she will want to outline the case for you. I suggest that you politely ask if they would just send the records to allow you to remain as objective as possible. You are trying to ascertain if the standard of care was met. This is a task that can be accomplished with objectivity if you are blinded to the outcome. You, of course, will be aware that something bad happened and it makes the review process all the more interesting to try and anticipate the final diagnosis.

Executive Editor: When you are participating in a deposition, how should an expert witness interact with the opposing lawyer?

Dr. Janiak: During depositions answer only what is asked. Sparring with attorneys can be a game of words and you can potentially compromise your position by waxing poetic. The emergency physician sitting at home answers the telephone: "Is Tina (your daughter) there?" "Of course," you say. "She will be right with you." In contrast, an attorney gets the same telephone call, responds "yes," and then hangs up the telephone. He answers the question that was asked and not the question that was implied. I have read many depositions of both defendants and experts who inadvertently open up a new line of inquiry by saying too much. The deposition is prolonged needlessly and potentially embarrassing issues can be brought to light. This is especially important if you happen to be a defendant. Answer most "yes or no" questions with a "yes" or "no." Rambling on in a defensive mode will only open the door to more questions. Your attorney will allow you a chance to explain your answers on cross-examination.

Executive Editor: What are some of the fine points of differentiating yourself from the opposing attorney's expert witness? We can assume your trial testimony will be honest and truthful, that's a given. So, how will the jury differentiate your believable testimony from your opponent's?

Dr. Janiak: You must, of course, know and be an expert on the topic you are being asked to opine over. However, you also must pay attention

to dress, personal demeanor, tone of voice, clarity, and firmness of your statements. Look each juror in the eye while speaking. Never allow yourself to get flustered when the opposing attorney challenges your statements. If necessary, take media training. On the other hand, if you still feel nervous about speaking in public, perhaps this kind of work is not for you.

Executive Editor: After doing this for almost 30 years, don't you worry that something you said previously or a case you defended years ago will contradict a current opinion?

Dr. Janiak: That is a very real possibility. During a trial the opposing attorney may say, "Dr. Janiak, do you remember the deposition in the Billings case you gave 15 years ago and what you said on page 53?" He may quote a paragraph that seems to impeach your current testimony. Your best bet in this situation is to ask to read the document. You will most likely find that you have been quoted out of context and can explain that to the jury. If, on the other hand, you have not been quoted out of context, you will learn the importance of consistency. Over time be consistent. Although there is no need to remember details, you must be consistent on major opinions. For example, if you stated 10 years ago that an emergency physician has a right to rely on a radiologist's reading, then stick with that opinion. Also, when rendering opinions, be sure you will be comfortable with a similar approach in future cases. And, in an individual case, be sure that your opinion letter (if written), your deposition testimony, and your trial testimony are all on the same track and consistent.

Executive Editor: What if you are asked for an opinion outside of your area of expertise?

Dr. Janiak: Always try to stay within your area of expertise. If you must opine outside the realm of emergency medicine, be very general. For example, you might say, "I believe the plaintiff's life span was shortened by the deviation from the standard of care by the doctor." It would be foolish to state that "Mrs. Smith would have lived another seventeen years." If you have no opinion about an issue, say that. You don't have to be knowledgeable about everything.

Executive Editor: How do you handle the situation when there has been a deviation from the standard of care, but there is no apparent causation?

Dr. Janiak: That happens. When there is no apparent link between the deviation and the outcome, don't hesitate to let your attorney know your opinion. In these cases, a plaintiff's attorney may want you to testify only about the deviation. Conversely, a defense attorney may want you to testify that there was indeed a deviation, but said deviation did not affect the outcome.

Executive Editor: How do you prepare for depositions or trials when there are reams of records and depositions to review?

Dr. Janiak: When preparing for depositions or trials, I focus on relevant names and time sequences. Not only will this shorten your time on the stand, but you will also become more confident in your overview of the case. By the way, remember that all your documents and notes are part of the case. Don't scribble anything on the deposition margins or notepaper you do not want to be questioned about.

Executive Editor: What are some common questions asked by attorneys during depositions and how do you answer them?

Dr. Janiak: During a deposition, an attorney may ask you which publications or texts you consider to be "authoritative." Admitting that any document is "authoritative" will allow the attorney to quote a sentence from the document that appears to be contrary to your opinion. I suggest that your answer be more realistic. It is more reasonable to respond that you agree with some parts of some documents, but you cannot give a blanket affirmation that the whole of any text is "authoritative."

Another common question an attorney may ask you is "Isn't it the job of an emergency physician to formulate a differential diagnosis?" I think it is appropriate to agree, but I also state that it is not necessary that the differential be in writing. A mental differential is appropriate. If you agree to the formulation of a differential diagnosis, then the next question will involve the "ruling out" of those items in the differential that are "life threatening." I prefer to answer that our obligation as emergency physicians is to rule out those diagnoses that are both life-threatening and have a reasonable chance of being the cause of the patient's complaints based on the history and physical and any tests results that are available. Remember, attorneys are more absolute than we are.

Executive Editor: How do you handle the question about your "exorbitant hourly charges?"

Dr. Janiak: Remember that you charge for your time, not your opinion. Be honest about your charges. The jury understands that this is an expensive process and will not be shocked by your hourly rate. Of course, it needs to be within a reasonable range.

Executive Editor: Are there any other pearls of medical-legal consulting that you can share with our readers?

Dr. Janiak: Sure, it is extremely important that you never answer a question you do not understand. Always ask for clarification. Take your time and consider your answer. Finally, if it is appropriate, don't be afraid to show you are human by adding a little tasteful humor. Smiling is also allowed. ■

continued from page 77
communicate with is very, very risky," says Warhaft.

In addition, if the physician doesn't fully understand the patient's complaint, there is a tendency to order extensive diagnostic tests to mitigate potential legal risks. "I am covering that which I don't understand by ordering additional labs and studies," says Warhaft.

Give patients "meaningful access"

To comply with federal regulations, you must provide "meaningful access" in your ED for non-English speaking and LEP patients, says **Sue Dill,** RN, MSN, JD, director of hospital risk management for Columbus, OH-based OHIC Insurance/The Doctors Company.

If you fail to provide this access, your ED could face malpractice lawsuits, fines, and violations of federal regulations, she warns.

"I think the potential risks are increasing as more EDs see more LEP patients," adds **Mara K. Youdelman**, a staff attorney with the Washington, DC-based National Health Law Program.

While federal regulations don't specify a time frame for providing translation services, some states do. For example, New York state now requires emergency departments to provide interpreters within 10 minutes.

Language barriers may affect the delivery of adequate care through poor information exchange, loss of important cultural information, misunderstanding of physician instructions, poorly shared decision-making, and difficulty obtaining informed consent, says **Edward Monico,** MD, JD, assistant professor in the section of emergency medicine at Yale University School of Medicine in New Haven, CT

Many courts have begun to interpret Title VI of the Civil Rights Act of 1964 as protecting individuals from language discrimination, based on the concern that language restrictions might veil discrimination based on race and national origin. Language discrimination also is covered under the Americans with Disabilities Act, notes Monico.

"The potential exists for malpractice lawsuits due to improper medical care, lack of informed consent, or breach of duty to warn, he says."

To reduce liability risks when caring for non-English speaking patients, do the following:

• Post a sign in your ED that reads "Interpreting services available at no cost to the patient" in the most common languages spoken by patients in your community.

A guidance from the Washington, DC-based Office for Civil Rights states that hospitals should notify patients of the availability of free interpreter services. (A complete copy of the guidance can be accessed at http://www.hhs.gov/ocr/lep.) Having a sign posted illustrates the hospital's recognition of the responsibility to provide competent language services and that it does not expect patients to bring family members or friends. "It also can help make patients more comfortable if they see information in their own language, and let them know that the hospital is trying to reach out," says Youdelman.

• Use competent interpreters. "There is a ton of medical literature on the issue of what constitutes cultural competence," says Dill. "Competency requires more than self-identification as bilingual." Bilingual staff or community volunteers may be able to speak Spanish when communicating information directly in that language, but they may not be competent to interpret in and out of English, or may not be able to perform written translations.

In addition, some languages have regional differences in usage of words or phrases. "A word that may be understood to mean something in Spanish for someone from Cuba may not be so understood by someone from Mexico," says Dill. Your interpreter must be aware when languages do not have an appropriate direct interpretation of certain terms and be able to provide the most appropriate interpretation.

• Avoid using family members to interpret.

"I would say that there is really no time that it is appropriate to use a family member except perhaps in an emergency while a competent interpreter is being obtained," says Youdelman.

Family members should not be used except in an emergency or if this is specifically requested by the patient, says Dill. If the patient asks that a family member is used, have the patient sign a waiver. "If a waiver is in the file, it may be more difficult for a person to later claim that an interpreter was not offered," says Youdelman.

Also have a competent interpreter listen in to ensure that the family member is indeed competent to interpret. "If the hospital allows the family member to interpret but has reason to believe the interpretation is not accurate, the hospital could still be at risk," explains Dill.

Verify the patient's request with an impartial interpreter and don't just take the word of the family member who is interpreting. "Also, make the patient aware that the services can be provided at no cost to the patient," says Dill.

Untrained interpreters may omit or add facts, substitute their own comments, or volunteer answers for the patient, says Youdelman. "They may also inject their own opinions and observations, or impose their own values and judgments as they interpret," she says.

Patients may not give complete information if family or friends are translating. "Using trained interpreters can ensure confidentiality, prevent conflict of interest, and make sure that medical terms are interpreted correctly," says Youdelman.

• Comply with the Emergency Medical Treatment and Labor Act (EMTALA).

Under EMTALA, you are required to assess and treat non-English and LEP patients just as you are for English-speaking patients. "There are particular EMTALA issues regarding potential transfers," adds Youdelman. "Patients will not be able to give consent to a transfer if a competent interpreter or translated materials are not provided."

Also, you may not be able to provide a medical screening examination as required by EMTALA if there is a language barrier and a competent interpreter is not utilized. "This could raise liability issues if the screening process is inaccurate and the hospital fails to provide treatment because of a failure to fully communicate with the patient," Youdelman says.

• Consider using video technology.

A growing number of EDs are implementing real-time video technology that allows staff to use a portable unit to speak with trained interpreters in more than 100 languages, including sign language. This system is called MARTTI (My Accessible Real-Time Trusted Interpreter) and was developed by the Columbus, OH-based Language Access Network. "It's almost as though the person is right in the room at your bedside," says Warhaft. "It allows me to communicate in real time in a very effective manner through the language barrier. This clearly reduces the risk profile of the encounter."

The cost benefits to the ED are direct and indirect, including both the savings of no longer having to maintain a cadre of interpreters, and the malpractice suit that never occurs, says Warhaft.

"Prior to MARTTI, we had to rely on anyone available to help with translations — family, non-medical personal, or AT&T telephone operators," says **Rhonda Robinson,** RN, ED manager at Olympia Medical Center in Los Angeles.

Whenever possible, ED staff used nursing staff to translate, with a list kept with the nursing supervisor of staff names and languages spoken, but depending on the time of day, these individuals were not always available. It was also legally risky to depend on the translator's perception of the patient's complaint and history, adds Robinson.

"Often patients felt very uncomfortable discussing health issues with family or friends, and would not always disclose the full complaint or medical history," she says.

There was also a patient confidentiality issue when using non-medical persons for help with translations. "Now the patient can see the translator, and the translator can see the patient and the ED physician, providing a more private process for all," says Robinson. "We can access this immediately and not have to wait for someone to assist us, which means the patient's complaint is addressed quicker." ■

Your ED could be liable if suicide assessment is poor

Assessments often done "haphazardly" by staff

NOTE: This is the first in a 2-part series on liability risks of psychiatric patients in the ED. Next month, we'll report on risks related to medical clearance of psychiatric patients.

A man is brought to your ED by his wife, who claims her husband is suicidal. You ask him if this is true and he convincingly tells you, "Absolutely not," adding that his wife is overreacting.

Does your assessment end there? If so and this patient later harmed himself, you could be held liable- and ED physicians have been sued for just this scenario.

"Psychiatric patients often get marginalized in EDs because of long waits and ambulance diversion, and can end up waiting 8 or 10 hours or longer and then leave," he says **Robert I. Simon**, MD, clinical professor of psychiatry and director of the program in psychiatry and law at Georgetown University School of Medicine in Washington, DC. Simon is author of *Assessing and Managing Suicide Risk: Guidelines for Clinically Based Risk Management;* published in 2004 by American Psychiatric Publishing.

By doing a thorough assessment for suicide risk, you might learn additional details that would make it very apparent that the patient was at high risk for suicide. *(See Table 1, SAD PERSONS Scale.)*

For instance, a family member might reveal risk factors that are highly specific to the patient waiting in your ED- information you wouldn't otherwise know. "The family may tell you that he stutters and when he stops stuttering, he is at high risk for harming himself. Those are the kind of things you won't find in any textbook," says Simon.

Suicidal patients are more likely to go to general EDs, which lack the resources of psychiatric emergency services in large medical centers, adds Simon.

In many EDs, suicide risk assessment is done "pretty haphazardly," says **Glenn Currier,** MD, associate professor of psychiatry and emergency medicine at the University of Rochester (NY) Medical Center. "This is especially true of smaller EDs that don't evaluate many psychiatric patients, and also those without an electronic medical record to prompt disease-specific questions and guide assessment," he says.

Here are ways to reduce risks when caring for a potentially suicidal patient in the ED:

• Consistently perform a thorough suicide risk assessment.

"Your assessment doesn't have to be fancy, but it does have to be adequate," says Simon. The purpose of a suicide risk assessment is to identify factors that inform patients' overall treatment and management requirements, with the goal of answering the question: Does the patient qualify for hospital admission or not?

A suicide risk assessment identifies acute and chronic factors as well as protective factors that may reduce risk, but it's the acute risk factors that will be the deciding factor in whether the patient is admitted or discharged from your ED. Your main concern is discharging the patient who is actually planning to harm themselves, but on the other end of the spectrum, patients may claim to be suicidal when they're actually looking for a place to sleep, says Simon. "It's important to assess behavioral risk factors, so as not to be totally dependent on what the patient is telling us," he says. These include agitation, severe depression, symptom severity, self-inflicted injuries, and responding to hallucinations.

There is no research showing that any one particular method can predict suicide, because none can. Your goal is to identify treatable risk factors which guide you as to whether the patient should be admitted or not. "You have to spend the time to do this," says Simon. "The problem is that many people have never been trained in how to do suicide risk assessments."

Assessments must be done consistently, no matter how "believable" the patient is. In one case, a physician was brought in by his family who told ED staff that he had made a noose and was threatening to hang himself. "He totally denies it, and because he's a physician, his statement is given credibility and is discharged," says Simon. The physician committed suicide within two hours after his ED visit.

After you do a risk assessment, you may learn that the patient is unable to work and is having marital problems. "Then all of a sudden you have a different picture," says Simon.

• Ask what patients have done to prepare.

Your patient may have stashed a bottle of pills or purchased a gun with the intent of harming themselves, but ED staff may never learn this if only a cursory assessment is done.

Always ask the patient specifically whether they have access to a gun, advises Simon. If the patient is going to be discharged, then tell a responsible person to remove any guns from the house and secure them so that they cannot be obtained by the patient. Always ask for a call back from this designated person to confirm that these steps were taken, and document that you asked for this confirmation.

"It can be an element of a malpractice claim that a callback was not requested when significant others were instructed to secure guns," says Simon.

• Be specific about your reasons for discharging a patient.

"I have testified in several malpractice cases involving the scenario of suicidal patients discharged from the ED," says Currier. "The one issue that appears almost constantly is that people do have a logic in mind for their decision, but they simply don't document it." As a result, the lawyers are free to challenge the thoroughness of the assessment.

"It's pretty clear that predicting suicide is an imprecise science, and physicians don't usually get nailed simply for making the wrong prediction about immediate risk," says Currier. Usually, once the physicians and nurses are deposed, it becomes clear that a reasonably thorough assessment was conducted but not documented by anyone. However, if better charting had occurred, the case would probably not have gone forward in the first place, says Currier.

If an ED physician decides to discharge a patient who was said to be potentially suicidal at triage, you should document the following at a bare minimum, says Currier:

- That an assessment of risk factors was done, including past suicide attempts, prior psychiatric history and

Sources

For more information, contact:

- **Sue Dill,** RN, MSN, JD, Director of Hospital Risk Management, OHIC Insurance/The Doctors Company, 155 E. Broad St., Fourth Floor, Columbus, OH 43215. Phone: (614) 255-7163. Fax: (614) 242-9806. E-mail: sue.dill@ohic.com.
- **Edward Monico,** MD, JD, Department of Surgery, Section of Emergency Medicine, Yale University School of Medicine, 464 Congress Ave., Suite 260, New Haven, CT 06519-1315. Phone: (203) 785-4710. E-mail: edward.monico@yale.edu
- **Rhonda Robinson,** RN, ED Manager, Olympia Medical Center, 5900 W. Olympic Blvd., Los Angeles, CA 90036. Phone: (323) 932-5241. E-mail: Rhonda.robinson@olympiamc.com.
- **Val Warhaft**, MD, Chief Medical Officer, Emergent Medical Associates, 111 N. Sepulveda Blvd., Suite 210, Manhattan Beach, CA 90266. Phone: (310) 379-2134. Fax: (310) 379-4856. E-mail: vwarhaft@ema.us.
- **Mara K. Youdelman**, Staff Attorney, National Health Law Program, 1101 14th St. NW, Suite 405, Washington, DC 20005. Phone: (202) 289-7661. Fax: (202) 289-7724. E-mail: youdelman@healthlaw.org. Web: www.healthlaw.org

Table 1

Modified SAD PERSONS Scale

Factor	Points
S = Sex (male)	1
A = Age (<19 or >45 years)	1
D = Depression or hopelessness	2
P = Previous suicide attempts or psychiatric care	1
E = Excessive alcohol or drug use	1
R = Rational thinking loss	2
S = Separated, divorced, or widowed	1
O = Organized or serious attempt	2
N = No social supports	1
S = Stated future intent	2

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admissions, substance abuse, family history of suicide, and planning/access to means for suicide; and an assessment of protective factors was also done, such as religious background and devotion to children.

- A statement that the patient's story is consistent with what they have told their family prior to arrival and the nurses and other staff since arrival.
- Clear documentation that both family members and outpatient health care providers were contacted and concur with the decision to discharge.

Currier recommends memorizing and documenting the following "punchline" in the patient's chart: "Based on the information available, this patient appears reliable, declines voluntary psychiatric care, and is asking to be discharged today. I do not believe he/she is at higher than usual risk of self harm and is not legally detainable at present. Patient and family were advised to come back to the ED should suicidal thoughts or plans worsen, and they agreed to do so."

"It's a lot to write, but 5 minutes during the shift could save you a court date later," says Currier.

Sometimes ED physicians assume that since a social worker or other individual did the mental health assessment, or the decision to discharge was made based on a phone conversation with the patient's psychiatrist, that they will be "off the hook" if that patient leaves the ED and commits suicide, but this is a mistaken assumption. "The ED doc assumes that since the social worker is really guiding the decision, that individual would be the point of reference for any aftermath that occurs. But that's not the way it works out in court," says Currier.

To protect yourself, you must document the logic behind your decision. Give a detailed version of why the decision was made, and use this wording: "I don't believe that this patient is at imminent risk of harm." "Otherwise, a patient can commit suicide three years after the ED contact, and from a liability perspective it can be a problem for you," explains Currier.

• Have a high index of suspicion for suicide risk even if patients present with unrelated complaints. When researchers screened 1590 patients in an ED waiting room who came for non-psychiatric reasons, 11% acknowledged passive suicidal ideation, 8% admitted that they thought about killing themselves, and 2% reported planning to kill themselves.[1] "People have to know that even if the patient didn't come in with a big "psychiatric" label on their forehead, it's still something they have to be mindful of," says Currier.

• Take input from family and others into account.

Sources

For more information, contact:

- **Glenn Currier,** MD, Associate Professor of Psychiatry and Emergency Medicine, University of Rochester Medical Center, Department of Psychiatry, 300 Crittenden Blvd., Rochester, NY 14642-8409. Phone: (585) 275-9908. E-mail: glenn_currier@urmc.rochester.edu.
- **Robert I. Simon,** MD, Potomac, MD. Phone: (301) 983-1270. Fax: (301) 983-9470. E-mail: risimonmd@aol.com

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. ■

The patient may vehemently insist they are not suicidal and were taken to the ED inappropriately, but instead of taking this at face value, "triangulate the history with somebody who knows the patient well," says Currier.

He gives the following example: A man who recently lost his job, is sullen and isolated, and has begun drinking alcohol more often than usual. He's brought in by police after making vague statements about not being able to "take it anymore" while being picked up for driving while intoxicated, but sobers up in the ED and flatly denies any intent to harm himself.

"The guy has no criminal or psych record and he talks a great game," says Currier. "But in talking to his wife, you get the feeling that there has been a really obvious decline in his ability to cope with even his own hygiene, and he has been eyeing his hunting rifles with a lot more interest lately, and recently bought ammunition even though hunting season is long over," says Currier. "That's the tipping point for admission."

Any decision to discharge this man that does not include written evidence of awareness of these new and important risk factors will be hard to justify. "Including this information in a note, but saying that the risk is nonetheless outweighed by other factors, is defensible no matter what the ultimate outcome," says Currier. ■

Reference

1. Claassen CA, Larkin GL. Occult suicidality in an emergency department population *Br J Psychiatry* 2005;186:352-353.

CNE/CME *Questions*

27. In determining whether public policy supported imposing a legal duty on Dr. Bailey in *Brown v. Bailey*, the court applied which factors?
    A. The economic burden upon the physician and the community
    B. The prevention of future harm
    C. The foreseeability of harm
    D. All of the above

28. For which scenarios is it advisable for ED staff to use family members as translators?
    A. Always, unless the patient objects.
    B. Only in an emergency while a competent interpreter is being obtained.
    C. Whenever patients cannot afford their own interpreter.
    D. After a medical screening exam is completed.

29. What do federal regulations require EDs to provide for patients with limited English proficiency?
    A. Meaningful access to care.
    B. Interpreters within ten minutes.
    C. Interpreters within 30 minutes.
    D. An interpreter only if the patient requests one.

30. Which is recommended for suicide risk assessment?
    A. Avoid documenting additional risk factors learned after the initial assessment.
    B. Defer the decision to admit or discharge to social workers.
    C. End your assessment if the patient denies being suicidal.
    D. Thoroughly document the logic behind your decision to discharge a patient.

Answers: 27. D; 28. B; 29. A; 30. D

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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.

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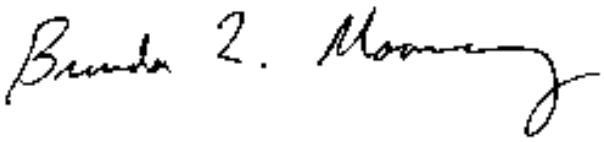

Brenda Mooney
Vice-President/Group Publisher
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