ED Legal Letter™

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

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

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IN THIS ISSUE

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OCTOBER 2007
VOL. 18, NO. 10 • (pages 109-120)

Arbitration of Disputes: How is it used in Medical Malpractice?

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Editor's note: *This is the first of a two-part series on arbitration of medical malpractice disputes. Part one will provide a brief overview of arbitration in general and of selected cases.*

Introduction

In arbitration, the parties agree to use an arbitrator or arbitration panel, as opposed to a judge or jury, to decide the outcome of their cases. More succinctly, arbitration is an alternative process for reaching a verdict in a case that is determined on its facts and merits. Arbitration has been defined as "an affirmative risk management [tool] that anticipates sources of conflict and puts in place systems to control costs and exposure to liability."[1]

Historically, arbitration was designed to privately resolve commercial disputes between businesses (having more or less equal bargaining power) that negotiated and agreed in a signed, written transactional document, to submit any future disputes to a binding decision by arbitrators who have expertise in the subject matter of that dispute.[2]

Arbitration is an adversarial, evidentiary process, somewhat less formal than a bench trial, in which parties tender a dispute to decision by either a solitary arbitrator or a panel of arbitrators. Typically, parties sign a written "arbitration agreement" stating that any future dispute between them will be arbitrated. If a dispute arises and the parties *must submit* their claim for arbitration; the process is "mandatory." If the parties *must accept* the arbitrator's decision as final, the process is "binding."

Arbitration to resolve medical malpractice disputes has long been recommended as a means to unclog crowded court dockets.[3] In many states, the legislature has paved the way for alternative dispute resolution. According to *Special Actions or Proceedings to Enforce Claims or Judgments*, "A written agreement to submit any existing controversy to arbitration or a provision in a written contract to submit to arbitration any controversy thereafter arising between the par-

ties is valid, enforceable, and irrevocable, save upon such grounds as exist at law or in equity for the revocation of any contract."[4]

While there is no question that medical malpractice disputes are arbitrable,[5] the use of arbitration clauses in contracts between providers and patients in the health care setting is distinguishable from their use in settling labor or commercial disputes inasmuch as the legal doctor-patient relationship is determined by both private contract law and public tort law. Thus, there is a tension between contract law, the principles of which have been applied to binding arbitration clauses in labor and commercial agreements for years, and the application of tort law to enforce conformity with standards of care desired by society, particularly with standards of professional care.[6]

This article will provide the reader with a brief overview of arbitration and its utilization in medical malpractice. To understand the role of arbitration in the malpractice arena, the paper will review selected cases and their outcomes in an effort to distill the legal basis behind the court's decisions. Finally, the article attempts to construct the essential elements of an arbitration agreement using principles learned from the cases below and the Federal Arbitration Act.

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

Subscriber Information: Customer Service: (800) 688-2421Customer Service E-Mail Address: customerservice@ahcmedia.com. Editorial E-Mail Address: suzanne.thatcher@ahcmedia.com. World Wide Web: http://www.ahcmedia.com. Subscription Prices: United States: $499 per year. Multiple Copies: Discounts are available for group subscriptions. For pricing information, call Tria Kreutzer at (404) 262-5482. Canada: $529 per year plus GST. Elsewhere: $529 per year. **Back issues: $83.** Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue's date. **GST Registration Number:** R128870672.

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Review of Selected Cases

Determining Enforceability. Even with a strong judicial deference to arbitration, some arbitration agreements are not upheld. This next section will discuss selected cases in an effort to determine the characteristics of agreements that are upheld in comparison with cases in which the agreement was not upheld in an effort to explore the basic tenets of drafting a defendable agreement.

Timing of the Execution of the Agreement. When a contract compelling arbitration is signed subsequent to the initiation of the patient-physician relationship, what is the court's position regarding the timing's effect on the agreement?

In *Coon v Nicola*, subsequent to the initial treatment of Mr. Coon at Ridgecrest Community Hospital for his injuries, the defendant surgeon performed surgery on a fractured wrist sustained after Mr. Coon fell down a mine shaft.[7] X-rays taken after his surgery revealed a previously undiagnosed fracture of Mr. Coon's left arm. The defendant physician informed the plaintiff of the missed diagnosis.[8] On a subsequent visit to the physician's office, Mr. Coon signed a physician-patient arbitration agreement. The agreement not only provided that claims regarding prospective care were to be covered by an arbitration agreement, but also included a provision concerning pre-agreement treatment.

At trial, Mr. Coon did not dispute that he signed the agreement and separately initialed a clause expressly agreeing to arbitrate disputes stemming from the care he received prior to signing. Despite the missed diagnosis, Mr. Coon continued to seek care from the physician for approximately 9 months. Mr. Coon argued that the statutory authority for physician-patient arbitration agreements does not authorize enforcement of retroactive agreements and that the appellant physician's attempt to enforce the agreement was unconscionable.[9]

The court noted that the determination of whether a contract is a contract of adhesion is "merely the beginning and not the end of the analysis insofar as enforceability of its terms is concerned."[10] Assuming arguendo that the patient-physician relationship by its very nature is unequal, the court also noted that "in order to be considered a contract of adhesion, the determination turns upon whether the terms of which [participant] was unaware are beyond the reasonable

expectations of the ordinary person or are oppressive or unconscionable."[11] The agreement that the plaintiff signed was on a separate one-page document entitled "Physician-Patient Arbitration Agreement" and all wording provisions required by statute were followed. Moreover, the arbitration agreement at issue also included a provision that allowed for revocation within 30 days.

The court, noting *Tunkl v Regents of University of California*,[12] reasoned that in many cases of adhesion contracts, "the weaker party lacks not only the opportunity to bargain but also any realistic opportunity to look elsewhere for a more favorable contract." In *Tunkl*, the hospital presented all incoming patients with a document entitled "Conditions of Admission" which provided that the patient release the hospital from liability for negligent or wrongful acts. However, unlike *Tunkl*, the agreement was signed at a post-surgery visit to the doctor's office and not in an emergency room or in an immediate treatment situation. "Most significantly, the present case does not limit appellant's liability in any way but merely provides for a different forum in which to settle disputes."[13] Hence, Mr. Coon's treatment was not predicated upon his signing the agreement. What is clear from this ruling is that an agreement is held to a "reasonable person" standard and care cannot be predicated upon the patient signing the agreement. Also, the agreement was only to change the forum, not to immunize the physician from negligence claims.

Does an Agreement with One Provider Cover Another Provider in the Same Group? In *Hilleary v Garvin*, an arbitration agreement was effective for all subsequent open-book account transactions for medical services, when the patient had voluntarily signed an agreement stating that any dispute as to medical malpractice would be submitted to arbitration.[14] Mrs. Hilleary signed the agreement upon her initial doctor visit for pregnancy. Later, she suffered a miscarriage and underwent surgery for removal of fibroid tumors of the uterus.

The patient presented to the medical group for a course of continuing treatment relating to complications of the miscarriage. The patient argued that the agreement covered the arbitration of medical services rendered in relation only to the pregnancy, [and] therefore was not relevant to the care she was currently receiving.[15] The court opined that based on the standard of whether a reasonable person would, from the conduct of the parties, conclude that there was mutual agreement, the court pointed out that the patient voluntarily signed the agreement explicitly stating that any dispute as to medical malpractice would be submitted to arbitration.[16] There was no evidence from which a reasonable person could conclude that the parties intended the follow-up surgery for removal of the tumors to be severable from the treatment for the pregnancy.[17]

From these cases, three distinct rules regarding arbitration agreements are clear: 1) An agreement can be signed after treatment has already ensued; 2) Patient care cannot be predicated upon the acceptance of an arbitration agreement; and 3) The agreement exists as long as a reasonable person would conclude that the care fell within the "spell of illness." ■

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10. Id. at 1234
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14. *Hilleary v. Garvin* 193 Cal. App. 3d 322 (App. Dist 2nd 1987)
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Decrease liability risks of sedation in your ED

Inappropriate requirements can harm patients

Increasingly, the anesthesia department is directing guidelines and training requirements for procedural sedation in hospitals, including the ED. Is this practice going to increase your liability risks?

Anesthesia should have no more role in directing

guidelines for procedural sedation in the ED than emergency physicians have in directing guidelines for the operating room, says **James R. Miner,** MD, FACEP, associate professor of emergency medicine at University of Minnesota Medical School in Minnetrista and faculty physician in the ED at Hennepin County Medical Center in Minneapolis.

"Procedural sedation in the ED requires a trained emergency physician to be performed adequately," says Miner. "It is much different than sedation in other specialties due to the unpredictable nature of the flow of care in the ED, the wide variation in the medical stability of ED patients, and the unpredictable NPO status of our patients."

Some anesthesia departments allow EDs to perform their own quality assurance and develop their own standards for procedural sedation, while others insist that sedation must be under the control of anesthesia, no matter where it occurs.

At Mount Sinai Medical Center in New York City, anesthesia requires that all physicians performing procedural sedation be certified and recertified in Advanced Cardiac Life Support (ACLS), including ED physicians, reports **Sheldon Jacobson,** MD, professor and chair of the department of emergency medicine. Also required is a training program in the use of agents and monitoring of patients before and after procedures. If ED physicians use a new drug for sedation, training is required and proof of attendance must be sent to anesthesia.

"We have found it much better politically to just go along with anesthesia's requirements," says Jacobson. "The medical board was persuaded that it is the safest thing to do. For me to say it's unnecessary — that doesn't seem to be a victory I can achieve."

Jacobson was also worried about liability exposure if the ED had overturned the policy successfully and a bad outcome occurred. "If we had fought with them and won, and then had complications, we would have really been at a very big disadvantage because we said we were able to do it without their interference and then had a disaster on their hands," he says. "Sometimes you have to know when to grin and bear it."

Procedural sedation is "probably used less frequently" in the ED as a result of anesthesia's requirements, acknowledges Jacobson. "All these hoops that we have to jump through have made us use procedural sedation less," he says. "We may use an analgesic agent instead of a sedating agent, which is safer, but not the optimal way of doing it."

Key Points

Procedural sedation guidelines for the ED should not be determined by anesthesia, since emergency medicine is different from other specialties, say experts in emergency medicine and procedural sedation. Inappropriate guidelines may prevent ED physicians from using the most appropriate agent, and result in procedural delays. To reduce risks:

- Train all caregivers delivering moderate or deep levels of procedural sedation in rescue airway management.
- Provide one-on-one monitoring until the patient returns to a pre-procedural level of alertness.
- Voice concerns about inappropriate criteria.
- Make sure all criteria are consistent with evidence-based guidelines.

Poor guidelines hinder ED care

In order to safely perform ED procedural sedation, a physician must be able to balance the risks and benefits of the situation, says Miner. This requires a detailed understanding of the patient's medical condition, the urgency of the need for sedation, and the risk of adverse events.

"Only emergency physicians are adequately trained in the care of patients in the dynamic environment of the ED to make this decision and perform the procedure appropriately," says Miner. "Furthermore, in the setting of adverse events, emergency physicians are the most appropriate physicians to provide airway management and resuscitation to the patient."

When physicians who are not trained or experienced in the care of patients in the ED attempt to make guidelines to direct the care given there, they are unlikely to be helpful, and can hinder the ED physician's ability to provide the care they are trained to give, says Miner.

In some cases, guidelines may prevent ED physicians from using the most appropriate agent for a given situation. "I have been contacted by numerous emergency physicians who are limited to using agents such as midazolam and fentanyl for procedural sedation, even for sedations that are brief or require deep sedation, despite that fact that research has clearly shown these agents to be inferior to agents such as propofol," he says. "It has been my experience that the people making these limits have little experience in the scope and requirements of ED procedural sedation."

Another example is absolute requirements concerning NPO status, which are not appropriate for the ED,

says Miner. ED physicians are experts in airway management for patients with variable NPO status, and are better suited and trained to make decisions balancing a patient's need for sedation with their risk of aspiration, he explains.

"An external requirement for NPO status designed for non-emergent patients can result in patients having unnecessary procedural delays, or not receiving sedation when they would have benefited from it," says Miner.

It's inappropriate for anesthesia to require ED physicians to attend ACLS courses to perform procedural sedation, says Miner. "This cannot be compared to the training a board certified emergency physician has received in the care and resuscitation of critically ill patients and the titration of sedative agents," he says.

Miner adds that he has seen credentialing requirements for procedural sedation consisting of a written test with material not relevant to emergency medicine.

"Tests are unlikely to have questions on it that have bearing on ED procedural sedation, unless a board certified emergency physician wrote the questions," he says. "The training requirement to perform procedural sedation on patients in the ED should be board certification in emergency medicine, and nothing else."

Hennepin County's procedure is that board certified emergency physicians, including the residents they train, are deemed qualified to provide procedural sedation. "I do not think non-emergency physicians are qualified to develop training requirements for emergency physicians," says Miner.

Make sure your ED is heard

If guidelines are set up by providers who do not routinely provide sedation in the ED and are not trained in emergency medicine, they are unlikely to be adequate or appropriate, says Miner. "Therefore, they will not improve patient safety or the outcomes of procedural sedation," he says. "It is very important to be involved in sedation guideline development, and to ensure it is designed with the proper practice of emergency medicine in mind."

If inappropriate guidelines or training are being required for your ED, there is plenty of research you can refer to, advises Miner. "There is a great deal of literature on the subject of procedural sedation in the ED," he says. "If guidelines are not following these recommendations, this can be referred to in arguments concerning the hospital's guidelines."

If the anesthesia department creates complicated or unrealistic requirements for your ED, approach the issue with a "multi-pronged effort," says **John Burton,** MD, residency program director of the department of emergency medicine at Albany (NY) Medical Center. He recommends citing evidence from the medical literature — both anesthesiology and emergency medicine — and specialty recommendations with evidence-based positions published in peer-reviewed literature.

Requirements for ED procedural sedation are "well described" in the medical literature, says Burton. He points to recommendations from the American College of Emergency Physicians, the American Academy of Pediatrics, and the American Society of Anesthesiologists. "Ensure that your ED's policies and procedures are consistent with the views of these groups, particularly those positions that are consistent throughout the literature," says Burton.

When debating about procedural sedation requirements, patient safety should remain a primary focus, says Burton. "Do not allow the turf interests that so commonly fuel these issues to dictate emergency medicine practice," he says.

If you feel that guidelines or criteria are inappropriate or inadvisable for your ED, make sure that a representative from the ED has the opportunity to be heard on the issue before the medical executive committee, says **Vicki L. Searcy,** CPMSM, practice director for credentialing and privileging at The Greeley Company, based in Marblehead, MA.

"It is in the best interests of an organization to make sure that there is thorough discussion while criteria and guidelines are being established, and that the final product is one that all practitioners who provide procedural sedation can and will follow," says Searcy.

There are two major liability risks associated with training requirements for procedural sedation: Failing to adhere to your organization's criteria, or having criteria inconsistent with accepted medical practice, says Searcy. Research the literature to be sure your criteria for which practitioners are eligible to be granted privileges for procedural sedation are defensible, she advises.

If specific training or monitoring of the amount of the practitioner's clinical activity in this area is required, your ED must have a system in place to collect this information. "Do this to avoid the situation of having an untoward occurrence and then finding out that the practitioner didn't meet the criteria to perform the privilege," says Searcy.

What are the biggest risks?

One major liability risk with procedural sedation involves failing to have proper preparation, with oxy-

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SPECIAL REPORT

The State of Emergency Ultrasound and the Standard of Care

*by **Edward P. Monico,** MD, JD, FACEP, FCLM, Assistant Professor, Section of Emergency Medicine, Department of Surgery, Yale University, New Haven, CT*

Introduction

Ultrasound is a modality requiring proficiency in both cognitive (indication and interpretation) and psychomotor (hands on) skills. Traditionally, ultrasound images obtained on emergency patients were acquired and interpreted by radiologists. However, limited access to emergency ultrasound has led emergency physicians (EPs) to become proficient in the acquisition and interpretation of ultrasound images performed for diagnostic and therapeutic reasons on emergency patients. Emergency physicians must now ask whether EP-performed ultrasound represents a convenient option or a legal obligation. This article focuses on the history of EP-performed ultrasound and whether this imaging modality triggers a new standard of care in emergency medicine.

While technology may not have been driving the evolution of emergency ultrasound, it certainly had its hand on the wheel. Compared to the first ultrasound instrument that was introduced during the 1950s, current ultrasound devices are smaller, faster, and more portable.[1] However, the technological advance most responsible for putting the ultrasound probe into the hands of the EPs was the development of real-time imaging. The procurement of images generated contemporaneously with the clinical exam and the ability to visualize continuous motion both provide valuable information during the early management of severely ill and injured patients.

Ultrasound's utility in the detection of free fluid in the peritoneal cavity was discovered in 1970.[2] It was not long before case reports appeared in the literature advocating ultrasound for the evaluation of patients who sustained blunt abdominal trauma.[3,4] The Focused Assessment with Sonography for Trauma, or FAST exam, followed this research and became the prototype emergency ultrasonographic exam performed by emergency physicians and trauma surgeons. Subsequent research sought other indications for EP-performed ultrasonography. These include: abdominal aortic aneurysm, ectopic pregnancy, thoracoabdominal trauma, pericardial effusion, determination of cardiac activity, biliary disease, renal tract disease, evaluation for DVT, and procedural guidance. Knowing at what point a legal obligation arises for EP's to perform emergency ultrasound requires an understanding of the role of the standard of care and negligence law.

Tort Law

The tort of negligence contains four elements:

1. the existence of a *duty*;
2. *a departure from customary and usual practice*; and
3. that the departure was a substantial *cause of injury* to the patient.

A plaintiff in a medical malpractice action must prove all of these occurred to prevail.[5] Typically, to satisfy this burden, plaintiffs use expert witnesses to distinguish the medical care in question from care regarded as acceptable by practicing physicians who are similarly situated. This "standard of care," therefore, is the legal vernacular for acceptable care by which all other care is measured.

Legal Precedent

The relationship between technology and medical liability is not novel to EP-performed ultrasonography. As one medical historian puts it, "…the development and implementation of new technologies and procedures have played a consistent and central role throughout the history of medical malpractice."[6] Studies of specific technologies and their associated liability indicate that claims increase when a new technology is introduced, and then level off over time. During a technology's infancy, however, there may be little evidence-based data that clearly define a standard of care. Case law provides some insight on how liability can arise in the absence of a clearly defined standard of care.

For example, in 1990 in *Washington v Washington Hospital Center,* the District of Columbia Court of Appeals affirmed a lower court's verdict against the hospital for medical malpractice when it failed to implement pulse oximetry to monitor anesthetized patients.[7] To arrive at its decision, the court considered hospital protocols, alumni newsletters, and personal correspondence between hospital administrators to define the standard.

As technology carves out new standards of care for physicians it also widens the schism between physicians who are able to comply from those who are not. While cost represents the patriarchal hurdle to the dissemination of burgeoning technologies, such as pulse oxime-

try, other factors contribute to the inertia associated with the widespread implementation of ultrasonography in emergency departments.

Acquired Skill

Ultrasound is a modality requiring proficiency in both cognitive (indication and interpretation) and psychomotor (hands on) skills. It has been suggested that training in both image acquisition and image interpretation must be provided through curricula that include didactic lectures, demonstrations, and technical skill laboratories.[8] Ultrasound is not only a learned specialty, but also one that requires maintenance of skills and familiarity with technology. While many emergency physicians currently emerging from training programs are well versed in the use of ultrasound, others with earlier training may be less acquainted with it.

Dissemination of Emergency Ultrasound

Despite the American College of Emergency Physician (ACEP) policy statement regarding ultrasound stating that "bedside ultrasound evaluation, including examination, interpretation, and equipment, should be immediately available 24 hours a day for emergency patients"[9] and that "emergency ultrasound procedures are standard emergency physician skills," penetration into community emergency departments has been slow. A longitudinal survey by the American Board of Emergency Medicine found that only 21% of board certified emergency physicians "personally perform bedside emergency ultrasound."[10]

Emergency Ultrasound as a Standard of Care

Despite access limitations and training hurdles, evidence suggests that emergency ultrasound should become standard of care practice in certain clinical scenarios. In 2001, under its "Evidence-Based Practice Program," the Agency for Healthcare Research and Quality (AHRQ) published Making Health Care Safer: A Critical Analysis of Patient Safety Practices.[11] The AHRQ publication detailed ways to decrease medical errors, with a chapter devoted to ultrasound-guided central venous access. The chapter noted that patients "with one or more risk factors, (e.g., critically ill patients on positive pressure ventilation with generalized edema and coagulopathy), may reap the greatest benefit" from this modality.[12]

In an addendum to the report, patient safety practices were rated by strength of evidence into one of five categories, from "lowest impact and/or strength of evidence" to "greatest strength of evidence regarding their impact and effectiveness." Use of ultrasound guidance to decrease morbidity from central venous catheterization was placed in the highest category, reflecting the greatest strength of evidence.[13] It should also be noted that among the 11 recommendations with the greatest strength of evidence, ultrasound guidance for central venous access was one of only two with an implementation cost/complexity that was rated as "high."

In addition to evidence from the AHRQ report, the ACEP policy statement specifically notes that "the use of ultrasound imaging by emergency physicians is appropriate in clinical situations ... and procedures that would benefit from the assistance of ultrasound."

Future Considerations

Future consideration should include ways to increase penetrance of emergency ultrasound into community emergency departments. The academic literature should strive for clarity when describing clinical scenarios where the standard of care includes ultrasound as either a diagnostic or therapeutic modality. Lastly, professional organizations should factor into the calculus the time to acquire new skills and equipment before formulating policy statements and obligating practitioners to a standard the practitioners cannot immediately conform to.

Summary

As the expectation that EP's acquire and interpret ultrasound images grows, so will the obligation. Policy statements from professional organizations and federal practice guidelines contemplate the use of ultrasound in emergency departments. The language used in these recommendations might trigger a standard of care in light of previous court opinions regarding the legal obligation to use new medical technologies. ■

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gen, suction, oral airway devices, and other supportive equipment readily available for rescue intervention in the case of prolonged apnea or laryngospasm, says Burton.

"Caregivers overseeing procedural sedation should be individuals who have had adequate rescue airway training for complications such as apnea, larnyngospasm, and hypoxemia," he adds.

Another liability risk is failing to dedicate one-on-one nursing care for patient monitoring from the inception of an altered level of consciousness to the return of a pre-sedation level of consciousness.

"While much attention is given to the current debate as to whether there should be two physicians in addition to the dedicated nurse, the cases I've seen in liability review have not focused on this question, but rather on the provision of one-on-one care throughout the period of impaired consciousness by any caregiver," says Burton.

The bottom line is that if a patient's level of consciousness is expected to be taken into levels of moderate or deep sedation during ED procedural sedation, there should be dedicated one-on-one monitoring until the patient returns to a pre-procedural level of alertness, says Burton.

The known risks of procedural sedation include aspiration pneumonia, hypotension, hypoxia, and emergence phenomenae, says Miner. "But they are so rare that the rates are not clear, and surrogate markers tend to be used in research," he says. Miner says he is not aware of any data showing that specific training requirements make any difference in outcomes.

In addition, complications in different settings are difficult to compare. For example, the sedation of trauma patients with displaced fractures for reduction is going to have a different complication rate than patients undergoing elective endoscopy in a gastrointestinal laboratory. "This makes the comparison of rates based on different training requirements difficult to do," says Miner.

Research on specific monitoring modalities continues to build, with a current area of debate involving the routine use of capnography during ED procedural sedation encounters, says Burton. However, the current science on rescue interventions and the training of caregivers for deep procedural sedation levels is "very

Sources

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clear and solid," he says. "We know what the risks of procedural sedation are in the ED setting, and the training and skills to address these risks is clear as well," he says. ■

Can your ED patient legally recover damages?

States taking stance against "runaway verdicts"

A misdiagnosed ED patient is awarded millions of dollars in "damages" — monies paid to an individual for the injuries he or she incurred as a result of negligent or intentional harm of the defendant.

This sounds simple enough, but many ED staff are not aware of the distinction between compensatory, non-compensatory, and punitive damages, and don't realize the many categories for which juries may award damages, says **Barbara Pilo,** a health care attorney counsel attorney in the litigation section of the Dallas office of Fulbright & Jaworski.

A person who suffers an injury or loss as a consequence of medical negligence in the ED setting would be entitled to recover damages that will, as nearly as possible, "restore the status quo" of the individual, says Pilo. "An award of damages is supposed to be commensurate with the loss, and excessive damages will be disallowed," she says.

Runaway verdicts

The types of damages patients can recover varies depending on your state's laws, says **Christy Tosh Crider,** a shareholder at Nashville, TN-based Baker, Donelson, Bearman, Caldwell & Berkowitz "However, some things remain the same," she says.

For one thing, all states allow for the recovery of "compensatory" damages if it's shown that the medical provider breached the standard of care, to compensate the patient for actual losses such as medical bills, funeral bills, lost wages, and lost earning capacity.

Plaintiffs also can recover punitive damages, designed to "punish" the medical provider for wrongdoing and discourage future misconduct, but this requires a higher threshold of proof. To recover punitive damages, patients might be required, for example, to show that conduct was "intentional" or "reckless." "The level of proof of wrongdoing is heightened to justify the imposition of punitive damages" says Pilo.

Punitive damages are based, in part, on the medical provider's financial worth, says Crider. "Many states have put caps on non-economic damages because of runaway jury verdicts with no real relationship to the actual losses suffered, and my opinion is that all should," she says. "They only serve to provide a windfall to one plaintiff and her lawyer at the expense of hundreds who will pay more for health insurance and medical care."

For instance, in 2007, a jury in McMinnville, TN, found an ED at fault for allegedly missing the signs of a heart attack in a patient. The jury awarded the man's family less than $10,000 in funeral bills, less than $200,000 in pecuniary damages — and $7,000,000 for loss of consortium, or the loss of his companionship. "This is an example of a runway verdict which drives up health care costs for everyone while providing a windfall to a few," says Crider.

As a result, many good ED physicians are choosing to practice only in states that have caps on damages, adds Crider. "This affects health care for millions more in states with no caps on damages," she says.

For example, in Texas, punitive damages now may be awarded only if there is a finding of fraud, malice, or gross negligence. Barring certain limited exceptions, punitive damages also are subject to a cap on the maximum amount and require a unanimous jury finding, says Pilo.

Additionally, the burden of proof required for a punitive award in Texas cases is a "clear and convincing" standard, a level of proof greater than the "preponderance of evidence" standard used in negligence cases, but less than the criminal standard of "beyond a reasonable doubt," says Pilo.

Damages vary widely

Two common scenarios in the ED that might give

Key Points

Patients may recover many different types of damages if harmed in the ED, including compensatory, non-compensatory, and punitive.

- All states allow recovery of compensatory damages.
- Some states have placed caps on punitive damages, and a greater level of proof is required.
- Long waits alone aren't enough to warrant damages, unless the delay resulted in a worsening of the patient's condition.

rise to a claim for damages are allegations of delay in treatment and misdiagnosis. However, the damages that might be incurred in these circumstances would vary widely, depending in large part on the severity of the patient's injury, says Pilo.

Compensation for pain and suffering is invariably claimed upon the filing of a lawsuit, but even this type of damage may be challenged if there is a question as to whether a plaintiff consciously experiences pain, says Pilo.

To illustrate the types of damages that may be available based on allegations of negligence in the ED, Pilo gives the following example of a complaint of headache which was not timely diagnosed as an intracranial hemorrhage, resulting in permanent neurological impairment. Here are damages that might be awarded in such a case:

- The pain endured in connection with rehabilitation and coping with disability would be compensable, as would be the future pain anticipated, since the injury will continue to affect the plaintiff for the rest of his/her life.
- The plaintiff potentially would be able to recover damages for mental anguish, prior to the verdict and continuing in the future, as well as amounts for physical impairment, disfigurement, past and future medical expenses, loss of household services, past loss of income and loss of earning capacity in the future.
- Depending on state law, a spouse or child may have a claim for loss of consortium, which would include such elements as loss of society and companionship.
- In the event that the alleged treatment in the ED results in death, the potential would exist for other types of damages. In Texas, a survival action may be brought for damages sustained by the decedent prior to death. Additionally, a statutory wrongful death claim exists in favor of the surviving spouse, children, and parents of the decedent, who may sue for "pecuniary loss." This refers to benefits that would have been received from the decedent if death had not ensued, including loss of consortium, mental anguish, and loss of inheritance.

When can't *damages be recovered?*

A litigant cannot recover damages that are speculative or conjectural, says Pilo. For example, a high school athlete who complains that a popliteal artery injury went undiagnosed in the ED, leading to compartment syndrome with amputation as an end result, might have a legitimate claim for damages from pain, suffering, medical expenses, and loss of earning capacity. "However, such an individual would have difficulty recovering for the claim of future loss of earnings as an NBA star," she says.

While a litigant may be compensated for mental anguish, there must be evidence to sustain such a damage award. For instance, a jury might award mental anguish damages if the plaintiff sustained a severe physical injury as a result of negligent treatment.

Mere disappointment, annoyance, or inconvenience would be insufficient to support an award of mental anguish damages. "An individual vexed by a long wait for removal of a non-infected foot splinter in an ED, crowded with patients more urgently in need of medical attention, might be hard pressed to show any damages. The additional minutes of pain experienced probably would be regarded as de minimis," says Pilo.

Being upset about having to wait for medical attention in the ED likely would not be enough, in and of itself, to warrant damages, unless the delay in treatment could be shown to have had a deleterious effect, worsening the condition that brought the individual to the ED, says Pilo.

Damages frequently are not capable of precise, mathematical calculation, particularly claims for intangible elements such as physical pain and suffering or mental anguish, says Pilo. "However, once proof of a recognizable physical injury from negligent care can be made, jurors have considerable latitude in assessing damages," she says.

Nonetheless, a litigant must still demonstrate a causal connection with the wrongful act alleged in the lawsuit. Damages must be the "probable and foreseeable consequence of the conduct that gave rise to the complaint," says Pilo.

"In cases originating in the ED, the trier of fact charged with determining damages frequently must

Sources

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distinguish between the medical problem which brought the patient to the ED in the first instance, and the damages attributable to the alleged departure from the applicable standard of emergency medical care," says Pilo.

For example, a litigant critical of a delay by ED personnel in treating the presenting symptoms of an evolving myocardial infarction with thrombolytics would have to demonstrate damages attributable to the time interval in which treatment was allegedly unavailable, says Pilo.

"Typically, this would involve showing that delayed medical attention led to an injury to the heart that would not otherwise have occurred," she says. The plaintiff also would have to show consequent damages, such as pain, mental anguish connected with physical disability, change in life style, or loss of earning capacity.

"To the extent that the litigant would have sustained these damages regardless of the events which transpired in the ED, damages most likely would not be recoverable," Pilo says. ■

CNE/CME *Questions*

39. The tort of negligence contains which of the following elements:?
    A. the existence of a duty;
    B. a departure from customary and usual practice; and
    C. that the departure was a substantial cause of injury to the patient.
    D. All of the above

40. Which is an example of inappropriate requirements for procedural sedation in the ED?
    A. Allowing use of propofol.
    B. Allowing ED physicians to make judgments regarding a patient's NPO status.
    C. Requiring caregivers to be trained in rescue airway management.
    D. Limiting ED physicians to use of fentanyl only.

41. Which reduces liability risks of procedural sedation in the ED?
    A. Having the anesthesia department be wholly responsible for developing guidelines without input from the ED.
    B. Requiring the exact same training for ED physicians as for all other departments.
    C. Ensuring that policies are consistent with evidence-based recommendations from specialty groups.
    D. Requiring one-to-one nursing care only for patients under deep sedation.

42. Which would patients have to show to recover damages for a delay in presenting symptoms of myocardial infarction?
    A. Consequent damages, such as loss of earning capacity.
    B. Damages attributed to the time interval in which treatment was unavailable.
    C. A causal connection with the wrongful act alleged.
    D. All of the above.

43. Which is accurate regarding damages recovered by a litigant?

CNE/CME instructions

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

CNE/CME objectives

After completing this activity, participants will be able to:

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

A. Compensatory and punitive damages always require the same level of proof.
B. No states have yet put caps on punitive damage awards.
C. Punitive damage awards require the same burden of proof as criminal standards.
D. A litigant cannot recover damages that are speculative or conjectural.

Answers: 39. D; 40. D; 41. C; 42. D; 43. D