ED Legal Letter™

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

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

AHC Media LLC

IN THIS ISSUE

Financial Disclosure: The following individuals disclose that they have no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study: Larry Mellick, MD, MS, FAAP, FACEP (executive editor), Professor of Emergency Medicine and Pediatrics, Residency Program Director, Department of Emergency Medicine, Medical College of Georgia, Augusta; Theresa Finerty, MS, RN, CNA, BC (nurse planner), Director, Emergency and Trauma Services, OSF Saint Francis Medical Center, Peoria, IL; Stacey Kusterbeck (contributing editor); John Shufeldt, MD, JD, MBA, FACEP, FCLM (contributing editor); Jorge A. Martinez, MD, JD (contributing editor); Suzanne Thatcher (Senior Managing Editor); and Lee Landenberger (Associate Publisher).

DECEMBER 2007
VOL. 18, NO. 12 • (pages 133-144)

Vicarious Liability and Independently Contracted Emergency Physicians

Is a hospital liable for the acts of independent contractor physicians?

John Shufeldt, MD, JD, MBA, FACEP, FCLM, *Chief Executive Officer, NextCare, Inc., Attending Physician/Vice Chair, Department of Emergency Medicine, St. Joseph's Hospital and Medical Center, Partner, Shufeldt Law Firm*

How can a hospital be sued by a plaintiff's attorney when the alleged negligence was committed by the independently contracted emergency physician? A competent plaintiff's attorney, when suing an emergency physician, will typically try to include the hospital so that his/her client has access to another source of funds.

There are several legal theories, derived from agency law, under which a hospital may be liable for the acts of an independent contractor physician who provides care in its emergency department. Legal theories, such as respondeat superior, apparent agency, ostensible agency, agency by estoppel, and nondelegable duty, are being used by plaintiff's attorneys to enjoin hospitals in claims against independent contracting physicians.

The general rule is that a principle (hospital) is only liable for its agents (employees) and not for the torts committed by its independent contractors (emergency medicine physicians). There are exceptions to this general rule, which include: when the principle is exerting so much control over an agent that the independent contractor status is negated; when the principle delegates a nondelegable duty; or when the contractor is performing an inherently dangerous activity.[1] It is generally accepted that hospitals cannot avoid liability simply based on their contractual relationship with the provider.[2]

Respondeat Superior

Respondeat superior is a legal theory, derived from agency law, where the master is liable for the negligent acts of its servant even though the master has no fault.[3] The Restatement of Agency § 220 lists the technical elements required for the master-servant relationship to exist. In part, these elements include: 1) the extent of control which, by the agreement, the master may exercise over the details

of the work; and 2) the skill required in a particular occupation.

Because of these requirements, plaintiff's have difficult hurdles to overcome to establish hospital liability under this theory. For example, the plaintiff has to prove the elements of malpractice (duty, breach of duty, causation, and damages) against the physician and then go on to prove an agency relationship existed between the hospital and provider; that the provider was the hospital's servant; and that the provider was acting within the scope of the relationship when the tort was committed.

In *Adamski v. Tacoma General Hospital* (Wash. Ct. App. 1978), the plaintiff, while playing basketball, suffered an open fracture. It was alleged the ED physician did not properly open and clean the wound, which resulted in the plaintiff having to seek further care. The plaintiff brought suit against the treating physician, the ED group, and Tacoma General Hospital, alleging that: 1) the ED physician's treatment was below the standard of care; 2) the ED physician was acting as an agent of the hospital; and 3) the hospital's employed nurses were negligent. The court ruled that because of their skill and training, physicians were not subject to the control of lay boards; therefore, they could not be servants or employees in the manner required by the doctrine of respondeat superior. For a number of years, the courts followed the rule from the Tacoma General case until *Bing v. Thunig* (NY 1957), in which the court reasoned that other highly skilled professionals were not being excluded from the doctrine of respondeat superior and that there were no valid reasons to exclude physicians.

Because of the difficulty encountered in satisfying the strict requirements under Restatement of Agency § 220, the courts have developed other avenues whereby hospitals can be held responsible for the negligent actions of their employees and their independent contractors. Even before the *Bing* ruling, the court in *Brown v. La Societe Francaise de Bienfaisance Mutuelle,* opined that if the hospital paid a doctor a salary, the doctrine of respondeat superior is applicable. It is under this theory that courts today generally hold hospitals liable for the negligent acts of their employed house staff.

Various legal doctrines are used by plaintiffs' attorneys to hold hospitals liable for the acts of their independent contractors. These doctrines include apparent (ostensible) agency or agency by estoppel and nondelegable duty.

Apparent Agency

For a plaintiff to prove that the hospital was vicariously liable for the acts of its independent contractor physicians, the facts would have to show that the hospital "holds itself out" as the employer of the independent contracting physicians *and* encourages patients to believe that the physicians are the hospital's agents. This is called apparent agency, ostensible agency, or agency by estoppel. For example, if a hospital advertises that "our" emergency physicians are the best in the state, a patient could logically assume that the physicians are actually employed by the hospital and because of that belief chose that hospital over its competitors.

The most common cases are those in which the agent has "apparent authority" to bind the principle that results from the principles' affirmative manifestations.[4] The landmark case in which this theory was elucidated was *Gizzi v. Texaco, Inc*.[5] In this case, Texaco was held liable for the acts of an independent contractor/dealer because of the following representation to the public, "You can trust your car to the man who wears the star." The dealer sold a car that had defective brakes to someone who was injured because

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.

AHC Media LLC is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

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

Approved by the American College of Emergency Physicians for 18 hours of ACEP Category 1 credit.

AHC Media LLC is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

This activity has been approved for 15 nursing contact hours using a 60-minute contact hour.

Provider approved by the California Board of Registered Nursing, Provider #14749, for 15 Contact Hours.

This activity is intended for emergency physicians and nurses. It is in effect for 36 months from the date of the publication.

Opinions expressed are not necessarily those of this publication, the executive editor, or the editorial board. Mention of products or services does not constitute endorsement. Clinical, legal, tax, and other comments are offered for general guidance only; professional counsel should be sought in specific situations.

Senior Vice President/Publisher: Brenda Mooney
Associate Publisher: Lee Landenberger
Senior Managing Editor: Suzanne Thatcher
Contributing Editors: Stacey Kusterbeck; John Shufeldt, MD, JD, MBA, FACEP, FCLM; Jorge Martinez, MD, JD.

Questions & Comments

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

of the defect. Although Texaco was not in the business of selling cars, and made no money from the transaction, they were still held liable because management knew the dealer was engaged in this business of selling cars and because of the advertisement. Courts using the principles of apparent agency to impose liability generally site one of two sections of either the Restatement (Second) of Agency or the Restatement (Second) of Torts. Section 267 of the Restatement (Second) of Agency states:

> One who represents that another is his servant or another agent and thereby causes a third person justifiably to rely upon the car or skill of such apparent agent is subject to liability to the third person for harm caused by the lack of care or skill of the one appearing to be a servant or other agent as if he were such.[6]

The other source for the imposition of liability comes from the Restatement (Second) of Torts. Section 429 states:

> One who employs an independent contractor to perform services for another which are accepted in the reasonable belief that the services are being rendered by the employer or be his servants to liability for physical harm caused by the negligence of the contractor in supplying such services, to the same extent as though the employer were supplying them himself or by his servants.[7]

Courts, in applying either principle, rely on several factors. One factor would be: Did the hospital make representations which would lead a reasonable person to conclude that the negligent party was the hospital's employee or agent? To arrive at their conclusion, the court will review advertisements from the hospital to determine if the hospital is "holding itself out" as a care provider.[8] Another factor would be: Did the patient rely upon this representation? The court will evaluate whether the patient believed the hospital was a provider of care as opposed to simply a location or venue of care.[9]

Courts apply either section (Agency or Torts) with inconsistent stringency, making it difficult to predict which way a court will rule when evaluating a plaintiff's claim of negligence under an apparent agency theory.

Nondelegable Duty

Simply stated, a nondelegable duty theory means that regardless of whether or not an agency duty exists, the hospital is essentially strictly liable as a matter of public policy inasmuch as the hospital cannot shirk liability by employing independent contracting physicians. The oft-employed analogy is an airline using independently contracted pilots to avoid responsibility in case of an airline crash. Thus far, this concept has been applied in only a few cases, all dealing with emergency medicine. The leading case is *Jackson v. Power.* In this case, Mr. Jackson fell off a cliff and was airlifted to Fairbanks Memorial Hospital. Because of this fall, Mr. Jackson suffered injury to his kidney which was not initially identified. Because of the delay, he suffered irreparable damage to his kidneys. The Alaska Supreme Court opined that, "a nondelegable duty is an established exception to the rule that an employer is not liable for the negligence of an independent contractor."[10] The court concluded that a hospital, "may not shield itself from liability by claiming that it is not responsible for the results of negligently performed health care when the law imposes a duty on the hospital to provide health care ... We simply cannot fathom why the liability should depend upon the technical employment status of the emergency room physician who treats the patient."[11] The questions still unanswered are whether this concept will extend beyond the emergency department and whether other states will adopt this theory. *Jackson* has been expressly rejected in Texas and Missouri. In those states that have accepted the nondelegable duty theory, there is little a hospital can do to limit its liability. In these states, no matter the perception of the patient, or whether or not a hospital held itself out as a care provider, the hospital essentially has strict liability for their independently contracted emergency physicians.

Summary

What can a hospital do, given the aforementioned, to mitigate the possibility of being held liable under an apparent agency theory? The most logical area is to concentrate on the marketing message. When the hospital, through its marketing message, transitions from a venue for care into a care-giving entity, it gives the impression that the hospital employs and thereby controls the physicians. In addition, when the hospital bills for the emergency services either as a separate item or as part of a global billing statement, it implies to the patient that the physician group and the hospital are one in the same.

The over-reaching interpretations that some courts have employed to enjoin hospitals has certainly affected the rising cost of medical malpractice insurance. To combat this, some state legislatures[12] are debating laws limiting the application of agency theory when it is applied to independently contracted emergency physicians. ■

References

1. Restatement (Second) of Torts § 414, 424, 416
2. Zaremski M, Spitz M. "Liability of Hospitals as an Institution: Are the Walls of Jericho Tumbling Down?" *Forum*

1980;16(2):225.
3. *Clark v. Southview Hosp. & Family Health Ctr.,* 628 N.E. 2d 46, 48 (Ohio 1994).
4. *Pepkowski v. Life of Indiana Ins. CO.,* 535 N.E.2d 1164-67 (Ind. 1989).
5. *Gizzi v. Texaco, Inc.* 437 F. 2d 308 (3d Cir. 1971).
6. Restatement (Second) of Agency § 267 (1957).
7. Restatement (Second) of Tort § 429 (1965).
8. *Sword v. NKC Hospitals, Inc.,* 714 N.E. 2d 151 (Ind. 1999). (The hospital advertised that it was the "most technically sophisticated birthplace in the region." An independent contractor anesthesiologist inserted an epidural that caused a persistent headache. In this instance, the hospital, because of its advertising, may have created the appearance that the physicians were actually employees.)
9. Id.
10. *Jackson v. Power*, 743 P.2d 1376 (Alaska 1987).
11. Id.
12. Illinois, Oklahoma, Georgia, Alaska, West Virginia, and Washington

Is your ED liable for patients' violent actions?

Consequences "severe" for failing to assess, document risks

If a man was discharged from your ED after being treated for injuries resulting from a fistfight, the ED record might state that the patient agreed to go into an anger management program and that he was given a referral to outpatient therapy. But most likely, it would neither document whether the patient had access to a gun nor other factors indicating that the potential for violence was assessed by ED staff.

Assessment of risk factors for violence such as gun access, gang affiliation, and history of police contact were not adequately documented for patients seen in a pediatric psychiatric ED, according to a recent study.[1]

If the above patient went home, got a gun, and shot the person he was initially aggressive toward, the ED could potentially be held liable, says **Jon T. Gatto,** a health care attorney with Buchanan Ingersoll & Rooney's Tampa, FL office.

"An emergency department should be very careful to take appropriate steps to document and prevent violence by patients, as a failure to recognize violent propensities can lead to liability for negligence," says Gatto.

While documentation of a thorough assessment can't fully protect you against a lawsuit, it can help to mitigate the ED's liability, says **Sandra Schneider,** MD, professor of emergency medicine at University of Rochester (NY) Medical Center. "If it were documented that the patient did not have access to a gun, that would likely help," she says.

Does the patient have a gun?

How much documentation is needed depends on the patient's presentation and chief complaint, says **Marisa A. Giggie,** MD, the above study's lead author and a psychiatrist at Taylor Hardin Secure Medical Facility in Tuscaloosa, AL.

"Obviously, if someone comes in suicidal, one must assess suicide risk. I argue that this should include an assessment of weapon access, given that guns are the most common form of completed suicide in adolescents," says Giggie.

One lawsuit involved an ED patient who threatened suicide and was then cleared through the psychiatric system, but completed the suicide later after new stressors occurred. "The ED was sued, though the case was later dropped," says Schneider.

At a minimum, Giggie advises that your documentation for patients coming to the ED as a result of a violent incident should include the following four things.

- Does the patient have a history of violence?
- Does the patient have access to weapons?
- Is there gang involvement?
- Does the patient have a history of police involvement?

She gives the following scenario: A child comes to the ED threatening to shoot someone, but there is no documentation of whether the child has access to a weapon or whether an attempt was made to have the police or family secure the weapon, if one is available.

Key Points

Assessment of risk factors for violence are often not adequately documented in the ED, says a recent study. If an aggressive patient later commits a violent act and the ED has no evidence that an assessment was completed, there could be liability exposure for the ED. To reduce risks:

- Document history of violence, weapon access, gang involvement, and police involvement.
- Screen all psychiatric patients for violence risk factors to avoid the appearance of discrimination or prejudice.
- Take appropriate action to protect the safety of others, which may include involuntarily commitment of the patient, contacting police, or contacting the potential victim.

"If the kid leaves the ED and shoots someone, then I think the ED could potentially get into legal trouble," says Giggie.

Since many violent patients have a history of violence, some EDs use a flagging system in the chart or a card system to warn the next provider of the potential for violence. "This system often is very helpful and necessary for patient safety, but may be frowned upon by legal groups who may suggest differential treatment based upon past infractions," says Schneider.

Similar concerns are raised with screening patients for violence. Ideally, your ED's screen is simply part of the chart, similar to the way many EDs screen patients for domestic violence, says Schneider. "The best thing is to screen everyone, with an equal screen," says Schneider. "If all women are asked the same questions about domestic violence, or all psychiatric patients asked about violence, there can be no question of discrimination or prejudice."

Sometimes ED staff do screen for violence in patients with psychiatric complaints, but the patient's response isn't documented. "The problem is they don't document the negatives, as this study shows. Therefore, if there is no mention of guns, we are not sure if there are no guns or if no one asked," says Schneider. "A checklist would be helpful."

Consider risk factors

When determining what to document for a potentially violent patient, consider these risk factors for violence, says Gatto:

- **Demographics.** Violence is more likely in males younger than age 30.
- **Roots/living situation:** Violence is significantly more likely for individuals who do not have roots in the community, and a patient who is transient is more likely to be violent than a patient living in a stable home. "When confronted with a potentially violent patient, document the patient's ties to the community and living situation," says Gatto. "Also document whether the patient is having any conflicts within his or her home. Domestic strife can often lead to violence."
- **Employment.** Document whether the patient is employed and whether the patient is having any conflicts at work. "A patient who is unemployed is more likely to be violent, and severe conflicts at work can lead to violence," says Gatto.
- **Access to weapons.** Document whether the patient has access to weapons, particularly guns, and also document what type of guns the patient has access to. "Access to a handgun or an assault rifle may, for example, be more indicative of potential violence than access to a hunting rifle," says Gatto.
- **Gang affiliation/drug trade.** Gang membership and involvement in drug distribution have an extremely high correlation with violence, says Gatto.
- **Substance abuse.** The type of drug that the patient uses also can be significant, as some illegal drugs may be more likely to lead to violent or erratic behavior than others, says Gatto.
- **Violent arrest record.** Document whether the patient has been arrested for any violent crimes within the past five years, says Gatto. "There is a high correlation between an arrest for a violent crime and future acts of violence," he says. "The specific crimes for which the patient was arrested should be documented."
- **Psychiatric symptoms.** Conduct a thorough screening for any psychiatric symptoms that may lead to violence, and document any history of psychiatric illness. "However, the ED should not necessarily presume that every patient presenting with psychiatric symptoms is potentially violent," says Gatto.

Propensity for violence should be assessed on a case-by-case basis, and those symptoms commonly linked to violence, such as paranoid schizophrenia and personality disorder, should be treated as warning signs of potential violence and be meticulously chronicled. "Symptoms of paranoia against or obsession with a particular individual or individuals may be a particularly dangerous sign, which should be thoroughly documented," says Gatto.

- **Organic symptoms.** Conduct a thorough screening for any organic symptoms that may lead to violence. "Patients who are in tremendous pain or are delirious from organic medical problems can be violent," says Gatto.
- **Immediate behavior.** Document a patient's threatening posture; increased motor activity; restlessness; or loud, profane speech. "Err on the side of documenting and taking appropriate safety precautions when there appears to be any small sign of violence," says Gatto.

Take appropriate action

Failure to recognize and properly stabilize a potentially violent patient can lead to negligence liability, says Gatto. "Where the violent propensities of a patient are properly documented and recognized, the ED can respond with appropriate physical restraints, pharmacological restraints, or security measures," he says. "If violent propensities are not properly documented and

—continued on page 140

SPECIAL REPORT

Spoliation of evidence and well documented ED records

*By **Jorge A. Martinez, MD, JD,** Professor of Clinical Medicine, Program Director, LSU Internal Medicine/Emergency Medicine Residency Program, LSU Health Sciences Center, New Orleans, Louisiana*

Introduction

The medical record is an essential component of the physician-patient relationship. It is used to document the interaction between patients, physicians, and other medical and non-medical personnel. Without the medical record, it would be impossible to coordinate appropriate, timely, and continuous medical care.

It also serves as a medical and legal document that facilitates non-verbal communication between physicians and other healthcare professionals participating in the patient's care. Importantly, it details treatment plans and describes the patient's response to treatment; provides evidence for medical fees and hospital charges; provides data for hospital audits, peer review activities, quality assurance, and medical research; and functions as a tool in educating medical students, house officers, nursing, and paramedic students. It also helps resolve controversies and refutes or supports medical malpractice claims. [1]

Because of its importance, any error correction on the chart must be addressed and noted appropriately. Documentation errors should be corrected by drawing a single line through the inaccurate statement. Importantly, the inaccurate statement should not be obliterated. White-out should never be used. The emergency physician (EP) should insert the corrected statement and sign his/her name and record the date of entry in the margin next to the corrected statement. Adding after-the-fact addendums should rarely occur. However, if necessary, the EP should note that the added information is a late entry, record the date and time of the entry, and limit the entry to the specific issue involved. The late entry should not eradicate any previously recorded information. Finally, medical records should never be removed from the hospital. Destroying or altering the medical record is "spoliation of evidence" and may subject the EP to civil and criminal liability. Two examples of spoliation of evidence are detailed below.

Spoliation of the Medical Record

Moskovitz v. Mt. Sinai Medical Center. In 1984, Moskovitz had a malignant tumor removed from her leg.[2] In 1986, Moskovitz visited Dr. F complaining of a lump on her leg. He noted a small calcified lesion on her Achilles tendon. Despite knowing that Moskovitz had a malignant tumor removed from her leg previously, Dr. F did not biopsy the lesion. Instead, he reassured Moskovitz that nothing was wrong.

In early 1987, Dr. F removed the mass from Moskovitz's leg, which was diagnosed as an epithelioid sarcoma. A bone scan revealed that the sarcoma had metastasized to Moskovitz's shoulder and femur. In November 1987, Dr. F transferred Moskovitz's care to Dr. M, who requested that Dr. F send him Moskovitz's medical records. Dr. F sent Dr. M seven pages of Moskovitz's medical records documenting her treatment from 1985 through 1987. Dr. M referred Moskovitz for radiation therapy. He sent her seven-page medical record to the radiation department. In December 1987, Dr. F requested that Dr. M return Moskovitz's medical records.

In January 1988, Dr. M requested that Dr. F return Moskovitz's medical record. In doing so Dr. F's office manager discovered that Moskovitz's original chart had vanished. In February 1988, Dr. M amputated Moskovitz's leg. In October 1988, Moskovitz filed a claim of medical malpractice against Drs. F and M, claiming that both doctors failed to diagnose her cancer and that Dr. M amputated her leg unnecessarily.

In January 1989, Dr. M produced a copy of Moskovitz's medical record at his deposition. Moskovitz's attorney noted that Dr. F had added several handwritten notes to his typed entries, including a statement that Moskovitz did not want the mass biopsied. In March 1989, Dr. F was deposed and produced a copy of Moskovitz's medical record. Dr. F's copy of Moskovitz's medical record did not contain several of the handwritten statements that were in Dr. M's copy. Furthermore, Dr. F's secretary's telephone logs contained notations penciled-in by Dr. F that stated that Moskovitz continued to refuse a workup of her leg tumor. Weeks later, a page of Moskovitz's chart was recovered from the radiology department which revealed that the final sentence of Dr. F's original entry in September 1987 had been whited-out. Moskovitz's medical record was eventually reconstructed from various copies. It demonstrated that Dr. F had never recommended that Moskovitz undergo a biopsy of her leg mass and that he had altered

the medical record in multiple places.

The Ohio Supreme Court found that "a cause of action exists in tort for interference with or destruction of evidence." According to the Court:

> [Dr. F's] alteration of records exhibited a total disregard for the law and the rights of Mrs. Moskovitz and her family ... the jury was presented with sufficient evidence, which, ... supported the inference that records were altered, destroyed or concealed by [Dr. F] ... in an effort to conceal his medical negligence ...

An intentional alteration, falsification, or destruction of medical records by a doctor, to avoid liability for his or her medical negligence, is sufficient to show actual malice, and punitive damages may be awarded whether or not the act of altering, falsifying or destroying records directly causes compensable harm.

The Court concluded that punitive damages for the alteration, falsification, and destruction of Moskovitz's medical records was consistent with the law and the evidence presented at trial.[2]

Carr v. St. Paul Fire and Insurance Company. The wife of the deceased sued the hospital for the wrongful death of her husband after he was discharged from the ED.[3] According to the facts presented at trial, when the deceased arrived at the hospital he was seen by an orderly, who took his vital signs and reported them to an LPN. He presented to the ED with vomiting, chest pain, and a history of diabetes. The deceased was evaluated and discharged from the hospital by the LPN without being seen by a physician. He later died from acute myocardial infarction secondary to severe atherosclerosis.

At the trial, the ED personnel testified that the deceased's vital signs in the ED were normal. However, they admitted that the deceased's medical record had been destroyed that night. They could not explain why it had been destroyed. The jury found that the hospital was negligent in the medical care provided to the deceased and awarded compensatory damaged to his wife.

The Court stated that:

> The plaintiff was greatly hampered in proving just what was done by the employees and what their examination disclosed, and the jury had a right to consider the effect that such destruction had in determining the actual facts ... [T]he jury certainly had a right to infer that the record, had it been retained, would have shown that a medical emergency existed and that a doctor should have been called and that more attention should have been given to [the deceased] than was given.[3]

Guidelines for Documentation of the Medical Record

To avoid spoliation of evidence errors and to ensure proper documentation, ED staff should keep the following in mind when making notes in a patient's chart. The EP should review nurse and paramedical personnel notes and reconcile any discrepancies. In doing so, the EP should not engage in "chart wars" or use demeaning or judgmental language. Instead, the EP should document pertinent facts and observations that support his correction of staffs' notes.

In addition, the EP should reference all documents that are not an integral part of the medical record. For example, the EP should document that a patient signed a consent form for a procedure; or signed an Against Medical Advice form before leaving the ED.

Extraordinary situations that arise during the any encounter with the patient should be described in a factual manner without dramatic, condescending, or demeaning language. Important statements made by the patient, family, bystanders, or health care providers should be marked with quotation marks. Finally, the EP should refrain from the urge to make the medical record entertaining or cute.

Discharge instructions should be written on a specified instruction form in plain, simple language. They should provide the diagnosis; specific instructions for home care, work, and activity; and directions for timely and appropriate follow-up care. The EP and nurse should review the discharge instructions with the patient during a discharge conference. If the patient is unable to understand, the patient's representative should be given the information. The patient or representative should sign the discharge instruction form verifying that the instructions were discussed, understood, and given to the patient.

Also, it is important to remember that the ED medical record should chronicle the physician-patient encounter in detail. As such, it should routinely include:

- the patient's means and time of arrival;
- chief complaint and physical presentation at triage;
- medications;
- allergies;
- immunization history;
- name of primary physician;
- pertinent history and physical examination;
- all written and verbal orders;
- a list of ordered laboratory and radiological studies, including the time ordered, the time performed, and the results of each study;
- a differential diagnosis;
- a treatment plan and treatment rendered;

- the patient's response to treatment;
- final diagnosis and disposition; and
- discharge and follow-up instructions.

The medical record must contain the individual's health history (supported by pertinent facts, findings and observations), physical examination, tests, treatment plan, and outcome of treatment.

In prolonged ED visits, the EP should repeat and reassess vital signs. The rule-of-thumb is that vital signs should be obtained at admit and at discharge. In addition, interval progress notes should detail patient reassessments and changes in clinical parameters. All actions taken to address clinical changes, as well as the patient's response to them, should be recorded.

Regulatory Agency Requirements for Medical Record Documentation

Dosages and Abbreviations. The Joint Commission for the Accreditation of Hospital Organizations (JCAHO) published a "Do Not Use" list, which lists abbreviations that may not be used in any handwritten patient-related material in a JCAHO accredited facility.[4] These may help make chart notations more clear and help avoid misunderstandings. The recommendations may be familiar, but bear repeating here because of their importance to clear communication.

Prohibited abbreviations include:

- "U" (unit);
- "IU" (international unit);
- "QD" (every day);
- "QOD" (every other day);
- "MS" (morphine sulfate or magnesium sulfate); and
- "MSO_4"and "$MgSO_4$" (morphine sulfate or magnesium sulfate).

According to The Joint Commission, the specific term for each abbreviation must be written. For example, a physician cannot write "25 mg of MS." Instead, the order must be written as "25 mg of morphine sulfate" or "magnesium sulfate." Likewise, a physician may not write an order for "12 U of insulin QD." The order must instead be written as "12 units of insulin every day."

Additionally, The Joint Commission forbids writing "X.0 mg" for a medication dose because the decimal point behind the number might be missed, leading to a dose ten times greater than the one ordered. Instead, all medication doses must be written as "X mg". Furthermore, a zero must precede a decimal point before a numerical dose of the medication. Thus, instead of ordering .3mg of versed, it must be written as 0.3 mg of versed. The intent is to assure that the decimal point preceding the dose is not missed.

In addition, The Joint Commission has proposed other abbreviations that should not be used in the medical record.[4]

- "H.S." (write "half-strength" or "at bedtime")
- "T.J.W." (write "3 times weekly" or "three times weekly")
- "S.C." or "S.Q." (write "Sub-Q", "subQ" or "subcutaneously")
- "D/C (write "discharge")
- "cc" (write "milliliter" or "ml")
- "µg" (write "mcg" or "microgram")
- "AS", "AD", and "AU" (write "left ear", "right ear", or "both ears")
- "OS", "OD", and "OU" (write "left eye", "right eye", or "both eyes")

Service Level Key Components. Proper documentation also is essential for correct billing. Therefore, it should be briefly mentioned that the Center for Medicare and Medicaid Services has established Evaluation and Management Service (E & M) levels which establish physician's fees based on the nature and complexity of physician services.[5] The four E & M levels are problem focused, expanded problem focused, detailed, and comprehensive. Generally, each E & M level is based on the patient's condition and the type and place of the medical services. Each level requires specific information in the medical record to support physician fees for that level. The three key components of each level are the history, physical examination, and medical decision making. ■

References

1. American College of Emergency Physicians, Policy #400181, February 2002. http://www.acep.org/practres.aspx?id=29604. Accessed on 11/7/07.
2. *Moskovitz v. Mt. Sinai Medical Center,* 635 N.E.2d 334 (Ohio 1994).
3. *Carr v. St. Paul Fire & Marine Insurance Company,* 384 F Supp. 821, 831 (WD Ark 1974).
4. Phillips MW. Avoiding medical errors: JCAHO documentation requirements. *J Am Dietetic Assn* 2004;104(2):171-173.
5. U.S. Department of Health and Human Services. Centers for Medicaid and Medicare Services. http://www.cms.hhs.gov/center/physician.asp. Accessed on 11/7/07.

continued from page 137

recognized, it can lead to liability in favor of other patients or hospital employees against the hospital."

The critical question in assessing whether a hospital is liable for a violent patient's behavior is whether the hospital "knew or should have known" of the likelihood of violence, says Gatto.

By making the correct inquiries and appropriately documenting those inquiries, the ED can help dispel any notion that it "should have known" about the patient's propensity for violence, Gatto says.

Examples of poor documentation practices that can lead to liability include the following:

- Failure to ask questions to determine propensity for violence;
- Failure to communicate such propensities to other emergency department staff;
- Failure to note any appropriate information indicating a propensity for violence on the patient's chart; or
- Failure to review the chart or medical history of the patient.

"Any of these omissions can lead to a potentially violent patient causing harm to others, for which the hospital may be liable," says Gatto.

Scenarios in which violent acts are carried out can be avoided or ameliorated through appropriate documentation and response, adds Gatto. "A failure to effectively document or communicate violent propensities can lead to significant liability," he says.

The most immediate threat posed by violent patients is the danger to those in the immediate vicinity, such as staff and other patients, says Gatto. "If an ED fails to ask the correct questions, document them, and communicate them to other staff, the consequences can be severe," he says.

For example, in one case, a phlebotomist sued a hospital for damages arising from an assault by a patient during a blood drawing.[2] The patient's previous caregivers within the hospital were aware that the patient had exhibited violent tendencies toward medical staff, but failed to advise the phlebotomist. The patient assaulted the phlebotomist, causing injuries to her left arm, and the phlebotomist successfully recovered damages from the hospital.

"There have been numerous other cases in which patients and employees have successfully sued hospitals for injuries sustained as a result of attacks by violent patients in the hospital setting," says Gatto.

Hospitals have been held liable for violent acts committed by patients even after their release from the hospital. In the famous case of *Tarasoff v. Regents of the University of California,* the California Supreme Court found the university liable for a psychiatrist's failure to warn a patient's former girlfriend of the patient's threats to kill her, which were made during a therapy session.[3]

"The Court ruled that health care providers owe a duty of 'reasonable care to give threatened persons such warnings as are essential to avert foreseeable danger,'" says Gatto.

In light of this case and many others that have followed, it is "highly important" that ED staff document any threat to the safety of others posed by potentially violent patients and take action accordingly, says Gatto.

Appropriate documentation includes asking the correct questions, documenting them thoroughly, and communicating them to every caregiver involved in the patient's care, he says. "Appropriate action includes involuntary commitment of the patient, contacting police, contacting the potential victim, or taking any other appropriate steps to prevent the threat posed by the patient from materializing," says Gatto.

A patient who comes to the ED threatening to shoot someone, or who is otherwise violent, should be physically restrained, if possible, and undergo a psychiatric evaluation, says **Richard J. Pawl,** MD, JD, FACEP, associate professor of emergency medicine at the Medical College of Georgia in Augusta.

"If the hospital makes all reasonable efforts to restrain this patient and fails, the hospital could still be sued, but would have a good defense to stand on," says Pawl. If the hospital was negligent in attempting to restrain the patient, or did restrain the patient and negligently allowed the patient to escape, knowing that the patient was threatening harm against others, there could be some liability. "The hospital could attenuate such liability by calling the local law enforcement agency and notifying them of the patient's escape," says Pawl.

If the patient is successfully restrained, then the ED must medically clear the patient by performing the medical screening examination mandated by the Emergency Medical Treatment and Labor Act (EMTALA).[4] If found to have no acute medical issues,

Sources

For more information, contact:

- **Jon T. Gatto,** Buchanan Ingersoll & Rooney PC, 401 East Jackson Street, Suite 2500, Tampa, FL 33602. Phone: (813) 222-8850. Fax: (813) 222-8189. E-mail: gattojt@bipc.com
- **Marisa A. Giggie,** MD, Taylor Hardin Secure Medical Facility, 1301 Jack Warner Parkway, NE, Tuscaloosa, AL 35404. Phone: (205) 556-7060. E-mail: marisa.giggie@gmail.com
- **Richard J. Pawl,** MD, JD, FACEP, Associate Professor of Emergency Medicine, Department of Emergency Medicine, Medical College of Georgia, 1120 15th Street, AF 2014, Augusta, GA 30912-2800. Phone: (706) 721-4412. Fax: (706) 721-7718. E-mail: rpawl@mail.mcg.edu
- **Sandra Schneider,** MD, Professor, Emergency Medicine, University of Rochester Medical Center, 601 Elmwood Ave., Room 2-1800, Rochester, NY. Phone: (585) 463-2970. E-mail: Sandra_Schneider@URMC.Rochester.edu

the patient may be legally committed to a psychiatric evaluation against his/her will, says Pawl.

The laws allowing such a patient to be legally restrained against one's will vary from state to state, but they generally rely on a medical person's assessment that the patient is any one, or all, of the following:

- Potentially harmful to himself;
- Potentially harmful to others; or
- Potentially so mentally impaired that he or she is not able to reasonably care for him or herself.

"Once the patient is committed to a psychiatric evaluation, the ED's liability is minimized," says Pawl. ■

References

1. Giggie MA, Olvera RL, Joshi MN. Screening for risk factors associated with violence in pediatric patients presenting to a psychiatric emergency department. *Journal of Psychiatric Practice* 2007;13:246-252.
2. *Powell v. Catholic Medical Center,* 749 A.2d 301 (N.H. 2000).
3. *Tarasoff v. Regents of the University of California*, 551 P.2d 334 (Cal. 1976)
4. www.emtala.com/law/index.html. Accessed on 10/30/07.

What are legal risks of videotaping trauma?

Educational value may be worth the risk

Many EDs videotape trauma cases for quality improvement and educational purposes, but some have put a stop to this practice due to concern about lawsuits. After the Health Insurance Portability and Accountability Act (HIPAA) became law, a study reported on a dramatic decrease in videotaping at U.S. Level 1 trauma centers. Prior to HIPAA, 58% of responding trauma centers used video compared to 18% afterward, reported the researchers. The most commonly cited reasons for stopping video use were legal concerns about patient privacy, consent, and discoverability.[1]

But what are the actual facts about liability risks of this practice? The first thing to consider is that videotapes of trauma cases and other procedures would be admissible in the event of a malpractice lawsuit, says **Linda M. Stimmel,** a partner with the Dallas, TX-based law firm of Stewart Stimmel. "A video of the healthcare provided — if that care is in question in a lawsuit — will definitely have to be turned over," says Stimmel.

Stimmel says she has seen the video help the defense in a labor and delivery case because it showed the care provided was timely, when the chart was not diligently documented. "I have also seen the reverse, when a video showed bad language and critical lapses in care that was used against the hospital at trial," she says. "So, it may depend on whether the care provided was appropriate."

If your ED videotapes trauma cases, use the tapes for educational purposes only, advises Stimmel.

Additionally and of utmost importance, the videos should be destroyed on a regular, consistent basis, she says. "There is no reason to keep videos in storage after their useful purpose is over," says Stimmel. "The destruction process must be consistent for all videos. You do not want videos laying around that people could view in violation of HIPAA."

Although you would definitely have to turn over a video if a lawsuit was involved, many lawsuits are not filed for up to two years after an event, notes Stimmel. "There is no reason to keep videos of all trauma cases for years if their useful purpose is over. The law does not allow us to destroy material at issue in a lawsuit, but there is no problem if we are taping for teaching purposes and then destroying all tapes on a regular basis," she says.

Key Points

Some EDs have stopped videotaping trauma and resuscitation cases due to concerns about patient privacy regulations and liability risks, but other EDs continue this practice because it has significant educational value. To reduce risks:

- Have only staff involved in the case view the tapes.
- Destroy the tapes after they are no longer useful.
- Obtain consent from patients or next of kin.

Sources

For more information, contact:

- **Alan Gelb,** MD, Clinical Professor of Medicine, Department of Emergency Medicine, University of California, San Francisco, Box 1377, 1001 Potrero Avenue 1E21, San Francisco, CA. 94143-1377. Phone: (415) 206-5754. Fax: (415) 206-5818. E-mail: agelb@sfghed.ucsf.edu
- **Linda M. Stimmel,** Stewart Stimmel, 1701 N. Market Street, Suite 318, Dallas, TX 75202. Phone: (214) 752-2648. E-mail: linda@stewart-stimmel.com

There is no set timeframe to keep a video, but the general rule is to keep them only as long as they are needed—if the tape is needed for a monthly seminar, destroy it after 30 days, advises Stimmel. "I would definitely let staff be aware they are being videotaped and that language will be on the tape," she says.

San Francisco General Hospital's ED has been videotaping trauma cases for 10 years, but there were significant concerns about liability raised by attorneys when this was first suggested. "When we first told the university and the city we wanted to do this, the initial response was 'No, that's not a good idea,'" says **Alan Gelb,** MD, the hospital's division chief of emergency services.

Hospital attorneys were concerned that the tapes might be discoverable and then used in a malpractice trial, but took into consideration that under California law, hospital's quality assurance activities (QA) are not discoverable, says Gelb. "Nothing is ironclad, but the statute states that the contents of meetings of physicians that are used for QA or PI [performance improvement] purposes are not discoverable," he says. "If they were discoverable, then it would hinder the ability of physicians to have candid discussions regarding how to improve things."

Although the statute doesn't specifically mention videotapes, the taping is done under the purview of the hospital's PI program, so Gelb believes the tapes would not be discoverable. "We have never had it tested or had a request or subpoena for the tapes," says Gelb. "If we don't use the tapes within a short period of time, then we erase them."

The ED's policy states that the tapes are used only for QA purposes and only the staff involved in the resuscitation may view them. About three years ago, the ED's policy was amended after a survey by The Joint Commission. "The issue was that even though we are only using the tapes for QA purposes, they wanted consent, which became a very difficult issue," says Gelb. "Many trauma patients die and those can be the most interesting cases in terms of learning and performance improvement. What we settled on, and they agreed to, was to get consent from the patient or next of kin. So that's made things a little more difficult now."

The consent that is required is the basic conditions of admissions that patients sign, which isn't a separate consent for the video, but it includes being filmed for QA purposes. "But if we can't get that, we don't use the tapes," says Gelb. "We don't get consent from the staff to be taped because it is considered part of working here."

Worth some risk

The benefits of videotaping trauma cases far outweigh any potential liability risks, according to Gelb. "It's good to be diligent in setting up your practice to protect yourself, but this is doable. It is so helpful from an educational and peer review standpoint—not just for the students and house staff but for the attendings as well," he says. "It's amazing what you see on those tapes. You think you did everything exactly right, but it turns out you could have done something better."

Usually the focus is not so much on the technical aspects of the procedures, but more on the organization, leadership, and how quickly things get done, adds Gelb. In fact, as a result of improved performance, an ED's liability risks may actually decrease, he suggests.

Gelb points out that the documentation of a resuscitation is discoverable, and everything that is seen on the tape is already recorded on the flow sheet that the scribe nurse fills out. He says that even if a jury viewed a tape, it wouldn't necessarily work against the ED. "In fact, I would think most of the time, the jury would get a sense of how many things are going on at one time," he says. "They would see how heroic things

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. ■

are, and it would help the defense. However, we would not try to play it both ways; these videos are taken for performance improvement purposes only. We would not introduce a tape in defense of a lawsuit no matter how favorable it might be." ■

Reference

1. Campbell S, Sosa JA, Rabinovici R, et al. Do not roll the videotape: effects of the health insurance portability and accountability act and the law on trauma videotaping practices. *Am J Surg* 2006;191:183-190.

CNE/CME *Questions*

47. Under respondeat superior, plaintiff's have difficult hurdles to overcome to establish hospital liability under this theory. For example, the plaintiff has to prove:
    A. the elements of malpractice (duty, breach of duty, causation, and damages) against the physician.
    B. an agency relationship existed between the hospital and provider.
    C. that the provider was the hospital's servant and that the provider was acting within the scope of the relationship when the tort was committed.
    D. All of the above

48. Under apparent agency, for a plaintiff to prove that a hospital was vicariously liable for the acts of its independent contractor physicians, the facts would have to show:
    A. that the hospital "holds itself out" as the employer of the independent contracting physicians.
    B. that the hospital encourages patients to believe that the physicians are the hospital's agents.
    C. that the physicians "hold themselves out" as independent contractors.
    D. Both a and b.

49. To reduce liability risks related to potentially violent ED patients, which is recommended?
    A. Staff should avoid asking direct questions about weapon access.
    B. No documentation is needed unless a specific threat is made.
    C. If an assessment of risk factors for violence is done, the patient's answers should always be documented.
    D. The patient's responses should only be documented if risk factors are identified.

50. Which is recommended regarding videotaping of trauma cases?
    A. Keep them in storage indefinitely
    B. Encourage all staff to view them, even if they were not directly involved in the case
    C. Don't inform staff that they are being videotaped
    D. Have a consistent destruction process for all videos

Answers: 47. D; 48. D; 49. C; 50. D

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*

ELB120107TM

CNE/CME Evaluation

Please take a moment to answer the following questions to let us know your thoughts on the CNE/CME program. Fill in the appropriate space and return this page in the envelope provided. **You must return this evaluation to receive your letter of credit. ACEP members — Please see reverse side for option to mail in answers.** Thank you.

CORRECT ● **INCORRECT** ⊘ ✓ ✗ ⚠

1. In which program do you participate? ○ CNE ○ CME
2. If you are claiming physician credits, please indicate the appropriate credential: ○ MD ○ DO ○ Other _____
3. If you are claiming nursing contact hours, please indicate your highest credential: ○ RN ○ NP ○ Other _____

After participating in this program, I am able to:	**Strongly Disagree**	**Disagree**	**Slightly Disagree**	**Slightly Agree**	**Agree**	**Strongly Agree**
4. Identify legal issues relating to emergency medicine practice.	○	○	○	○	○	○
5. Explain how these issues affect nurses, physicians, legal counsel, management, and patients.	○	○	○	○	○	○
6. Integrate practical solutions to reduce risk into the ED practitioner's daily practices.	○	○	○	○	○	○
7. The test questions were clear and appropriate.	○	○	○	○	○	○
8. I am satisfied with customer service for the CNE/CME program.	○	○	○	○	○	○
9. I detected no commercial bias in this activity.	○	○	○	○	○	○
10. This activity reaffirmed my clinical practice.	○	○	○	○	○	○
11. This activity has changed my clinical practice.	○	○	○	○	○	○

If so, how? _____

12. How many minutes do you estimate it took you to complete this entire semester (6 issues) activity? Please include time for reading, reviewing, answering the questions, and comparing your answers with the correct ones listed. _____ minutes.
13. Do you have any general comments about the effectiveness of this CNE/CME program?

_____

I have completed the requirements for this activity.

Name (printed) _____ **Signature** _____

Nursing license number ***(required for nurses licensed by the state of California)*** _____

Please make label address corrections here or PRINT address information to receive a letter of credit.

Account # _____

Name: _____

Company: _____

Address: _____

City: _____ State: _____ Zip _____

Fax: _____ Phone: _____

E-mail: _____

PLEASE NOTE: If your correct name and address do not appear below, please complete the section at left.

In accordance with ACEP requirements, below we provide the option for ACEP members to submit their answers for this CME activity. If you wish to submit answers to this activity, please refer to Vol. 18, Nos. 7-12 and circle the correct responses.

JULY 2007

Liability of physicians

27. A B C D

28. A B C D

29. A B C D

30. A B C D

AUGUST 2007

Patient safety organizations

31. A B C D

32. A B C D

33. A B C D

34. A B C D

SEPTEMBER 2007

ED overcrowding

35. A B C D

36. A B C D

37. A B C D

38. A B C D

OCTOBER 2007

Arbitration of disputes

39. A B C D

40. A B C D

41. A B C D

42. A B C D

43. A B C D

NOVEMBER 2007

Arbitration of disputes: Part II

44. A B C D

45. A B C D

46. A B C D

DECEMBER 2007

Vicarious liability

47. A B C D

48. A B C D

49. A B C D

50. A B C D