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Medical Malpractice Insurance: That Pesky "Tail" Problem

by John E. Barton, JD, MBA, CPA, and Robert A. Bitterman, MD, JD, FACEP, Contributing Editor

Emergency physician groups have dealt with the realities of claims-made liability coverage for years now, yet many continue to be unpleasantly "surprised" when it comes to their "tail coverage." Tail coverage: allows the insured an extended period of time for the claim to mature or be reported to the insurance company.

Note From the Authors. This article examines some of the commonly overlooked issues related to the structure of claims-made insurance coverage and its "tails," and the impact that poor planning related to such coverage can have on the group and the individual emergency physicians.

Three real-life scenarios are presented. Please recognize that the language in each malpractice carriers' policy is different and that the specific language of your policy governs your particular tail coverage. Additionally, every situation is highly fact dependent and these scenarios may not arise under your policy. Please discuss your particular situation with an adviser you trust if you have any concerns.

Our goal is to raise your awareness of the potential difficulties related to tail coverage. After reading the explanation of the concepts that follows, and the consequences of the scenarios presented, you should have a greater understanding of how to effectively address your liability "tail."

Scenario One

Group A has six emergency department (ED) contracts. The group has claims-made coverage under a group policy — all six of the facilities are insured under one policy. Group A loses one of the contracts and ceases to provide service at the facility on 12/31/07. The group policy stays in force and no "tail" is purchased for the lost contract.

What is the impact to Group A of the lost contract?

Scenario Two

Group B is a 15-physician ED group. Group B has claims-made coverage with per physician policy limits rated on a full-time equivalent (FTE) basis. Group B had struggled to find and pay for insurance coverage, so it purchased a $100,000 per

occurrence deductible with an annual aggregate deductible of $300,000 for the policy holder. There is an oral agreement among the physicians that the deductible will be borne by all members of the group. Physician X leaves the group for greener pastures; the group purchases the tail and the tail policy is issued with physician X as the policy holder.

What is the impact on physician X?

Scenario Three

Dr. Newbie joins Group C on 1/1/2003, three years after completing her residency. Dr. Newbie's employment contract with Group C provides that C will provide Newbie with an individual claims-made policy with $1million/$3million limits. Dr. Newbie's policy is unrestricted, but C is not obligated to purchase Newbie's "tail." If the tail is purchased, the tail policy will be issued in Newbie's name.

Dr. Newbie begins moonlighting for Group Y on 07/01/07. Group Y has a "slot rated program" with a retroactive inception date of 07/01/07 — the day she began moonlighting for group Y. At 12/31/07 Newbie decides to leave Group C to go work for Group Y.

Will Group Y provide Newbie "prior acts" coverage for the period Newbie was with Group C? What is the impact on Dr. Newbie? What impact does Newbie's policy with Group C have on Group Y?

Some Terminology and Basic Concepts

Basic definitions:

- Deductible — the portion of a covered loss that is not paid by the insurance company.
- Group policy — a single policy that combines a number of locations or a number of insured physicians (the "insureds") into one policy.
- Slot policy — a policy that covers a position or "slot" instead of being issued to a named single individual physician.
- Rating — the basis on which rates are applied to determine the amount of premium that will be paid to purchase insurance (hours, visits, full-time equivalents, etc.)
- An "unrestricted" policy is a policy that covers the individual physician, even if the physician works at multiple hospitals or at hospitals outside of the ED group.
- A "restricted policy" for an emergency physician typically just covers the physician's practice at hospitals under contract with the ED group that is providing the insurance for the physician. The physician would have to arrange additional insurance coverage if working in an ED for another group.

Occurrence vs. Claims-Made Coverage and How the 'Tail' Comes Into Play

In a kinder and gentler time, **"occurrence"** malpractice coverage was prevalent in the marketplace. An occurrence policy covers any incident that occurs while the policy was in force, regardless of when a claim related to the incident is presented to the insurance company. Contrast that with a **"claims-made" policy**, which covers any incident occurring during the policy period, so long as the claim that results from the incident arises during the "reporting period" (typically while the policy is in place and for 60-90 days after the policy has expired). This is not to be confused with a **"claims-made and reported policy"** which requires that the claim be made *and actually reported to the insurer* within the policy period. This type of policy can be problematic if the insured physician becomes aware of the claim very late in the reporting period.

So "claims-made" and "claims-made and reported" policies both have a timing element associated with the claims. If an incident occurs during a claims-made policy period but does not mature into a claim until after the coverage expires, the claim would not be covered.

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To deal with this liability exposure, the insured must either purchase new coverage with a retroactive date starting with the end of the old claims-made policy (called "prior acts" coverage with a stipulated retroactive date) or purchase a "tail."

A "tail" is really just an "extended reporting period" endorsement. The "tail" allows the insured physician an extended period of time for the claim to mature or to be reported to the insurance company. The "tail" contract can extend the reporting period for different lengths of time: 1, 2, or 5 years or even indefinitely. If the claim is reported *during* the tail period, it will be covered by the insurance contract. If the claim is reported *after* the original reporting period or *after* the extended tail period, whichever period is longer, the claim will not be covered.

"Tail" Mechanics

If a "tail" is not purchased, and the subsequent malpractice insurance coverage does not contain "prior acts" coverage with an inception date back to the date the old claims-made coverage stopped, there is uninsured liability exposure for the physician. If a claim related to an incident that occurred during the policy period arises during this "bare" period, there is no insurance coverage and the physician would be personally liable for the amount of the claim.

Typically, medical malpractice policies provide that when the policy is terminated (for any reason) the insured physician has the right to purchase a tail. The policy language will vary regarding the mechanics of the purchase. In most instances, when the insured physician gives notice of termination to the insurance company, the company will provide the insured physician an offer to purchase the tail. The insured then accepts the tail offer by paying the premium within the timeline laid out in the underlying policy. Nonpayment or late payment of the premium will be deemed a rejection of the insurer's offer for the tail policy, meaning the physician will not have tail coverage.

Whenever the malpractice insurance company (often referred to as a "carrier" by the states) is "admitted" in the state in which the policy was written, the price of the tail is determined in accordance with rates that the company files with the state. If the carrier is not admitted, then the rate will vary depending on how long the claims-made policy has been in force. If the carrier is not "admitted" in your state, then the details regarding the "tail" coverage will be included in the contractual language of your policy.

Discussion of Scenario One

Group A has six ED contracts. The group has claims-made coverage under a group policy — all six of the facilities are insured under one policy. Group A loses one of the contracts and ceases to provide service at the facility on 12/31/07. The group policy stays in force and no "tail" is purchased for the lost contract. What is the impact of the lost contract to Group A?

Since the group policy stayed in force, technically no "tail" had to be purchased at the time the group lost one of its ED contracts. However, since this is claims-made coverage, prior acts exposure still exists from patients seen before the insurance coverage there ceased. Depending on the terms of the policy issued by the insurance carrier, the group could be charged an additional premium each year to fund the prior acts exposure. That's right, though no "tail" is issued, under the group policy contract charges may be assessed against Group A that the physicians at the five remaining facilities will have to pay. Total premiums charged on an ED that sees 30,000 visits annually could easily exceed $300,000.

What is the impact to Group A if the exposures were not resolved through the payment of the additional premium? The members of Group A now have a new unfunded contingent liability.

Assume that all physicians are retained and assimilated into the five remaining facilities. Assume further that five months later a claim arises from an incident at the lost facility against Dr. Lucky, a member of Group A. Since the group policy is still in force, Lucky's claim would be covered. In fact, if the group policy remained in force for an extended period, the incurred but not reported claims that existed at 12/31/07 would presumably arise and the exposures would essentially be resolved, eliminating the potential liability.

However, what happens if the group policy is terminated (for whatever reason) within a year? The incurred but not reported exposures related to the lost facility would not all have matured and presented. As a result, the exposures related to the lost facility *would be included* in the tail premium Group A would have to pay when the group policy is terminated. Obviously, this would be an additional cost that the group may not have been expecting.

Until the incurred but not reported exposures related to the closed facility are mature, the members of Group A would have a contingent liability relating to the tail for the lost facility.

Discussion of Scenario Two

Group B is a 15-physician ED group. Group B has claims-made coverage with per physician policy limits rated on a full-time equivalent (FTE) basis. Group B had struggled to find and pay for insurance coverage, so it purchased a $100,000 per occurrence deductible with an annual aggregate deductible of $300,000 for the policy holder. There is an oral agreement among the physicians that the deductible will be borne by all members of the group. Physician X leaves the group for

greener pastures; the group purchases the tail and the tail policy is issued with physician X as the policy holder. What is the impact on physician X?

The focus under this scenario is on the details associated with the issuance of the policy. Given the structure and rating mechanism of the policy, Group B has no real choice. For physician X to be protected, a tail will have to be purchased. Further, the group has already addressed the question of who will bear the cost. Physician X will be the one potentially surprised here — the "tail" policy will be issued in Dr. X's name *with* a $100,000/$300,000 deductible! The tail will be issued with same deductible that exists for Group B. Now Dr. X, having left the group, will have to fund the deductible on his own if a claim arises.

Was the impact of the deductible fully understood by Group B? If understood, was it adequately communicated to the individual physicians? Will the officers of Group B be covered under the group's D&O policy for the lawsuit that will be filed by Dr. X if he gets sued?

Discussion of Scenario Three

Dr. Newbie joins Group C on 1/1/2003, three years after completing her residency. Dr. Newbie's employment contract with Group C provides that C will provide Newbie with an individual claims-made policy with $1million/$3million limits. Newbie's policy is unrestricted, but C is not obligated to purchase Newbie's "tail." If the tail is purchased, the tail policy will be issued in Newbie's name.

Newbie begins moonlighting for Group Y on 07/01/07. Group Y has a "slot rated program" with a retroactive inception date of 07/01/07 — the day she began moonlighting for group Y. At 12/31/07 Newbie decides to leave Group C to go work for Group Y.

Will Group Y provide Newbie "prior acts" coverage for the period Newbie was with Group C? Of course the answer is "it depends," but its likely that Group Y will *not* be inclined to pick up the prior acts coverage for Dr. Newbie. Group Y has designed its program so that the "slot" coverage will continue to stay in place regardless of turnover — so no "tail" purchases will be required until the coverage for the "slot" itself changes and necessitates it. Although Dr. Newbie may have the negotiating clout to convince Group Y, it is going to be a difficult sale.

What is the impact on Dr. Newbie? If Newbie leaves, she will be forced to individually purchase the "tail" or go unprotected. The cost of the tail will depend on the details of policy in force and the premium charged, but a $50,000 to $80,000 cost could easily be possible. This unexpected (after tax) expense may cause Dr. Newbie to reconsider her departure.

What impact does Newbie's policy with Group C have on Group Y? The unintended consequence of the unrestricted policy is an overlap of limits. Groups C and Y's policies would both offer coverage for claims that occurred while Newbie was moonlighting for Y.

Conclusions

In the days of occurrence coverage, things were much easier. Though occurrence coverage is once again becoming available, it is not prevalent and the conversion to occurrence comes with its own set of potential financial repercussions. As a result, most groups will be constrained to continue with claims-made coverage. Unfortunately, the complexities of this coverage create significant exposures if not properly understood and planned for.

The starting point for overcoming these potential exposures is to take stock of your current arrangements, with particular focus on how the current structure may impact the group and the individual physician members. If necessary, seek out technical advice from an adviser you trust — and then act. The current insurance market is relatively soft and carriers are pricing aggressively. It is best to address your problems now, while solutions are affordable. ■

Sources

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Be aware of liability risks if you fail to give high-dose steroids

Treatment is "perceived" standard of care for spinal cord injuries

There is now considerable data indicating that the use of high-dose steroids for spinal cord injuries is not effective and can even be harmful to patients. Despite this, are ED physicians still "obligated" in a legal sense, to administer high-dose steroids to patients with spinal cord injuries?

"The simple answer is yes," says **Donald H. Schreiber,** MD, associate professor of emergency medicine at Stanford University in Palo Alto, CA. "Steroids are still given, even if they are not effective and despite considerable risk of adverse events — sepsis, pneumonia, and avascular necrosis."

Failing to give them could lead to a malpractice lawsuit if an adverse outcome occurs, and steroid administration "is absolutely still an issue" in ED malpractice litigation, says Schreiber. "The most common malpractice claims are for not giving steroids, giving an incorrect dose, or not giving them within the mandated time frame."

Most ED physicians continue to give steroids because of concerns about medical-legal risk or institutional policy, says Schreiber. In a recent study, although 90.5% of spine surgeons surveyed used a steroid protocol for spinal cord injury patients, only 24.1% used it due to a belief in improved clinical outcomes. The most common justification (38.3%) noted for using steroids was fear of medicolegal issues.[1]

The same findings would undoubtedly apply to ED physicians, says Schreiber. "Our policy at Stanford is to give steroids because it's the 'perceived' standard of care," he says. "Many people feel that it 'can't hurt.'"

The "standard of care" as a concept is fluid — as more evidence is obtained, evaluated, and critically appraised, practice should change accordingly. "The use of steroids in spinal cord injuries is no different," says **Dan Cass,** MD, FRCPC, staff ED physician at St. Michael's Hospital in Toronto, Ontario, Canada.

Cass is lead author of the Canadian Association of Emergency Physicians (CAEP) position statement on use of steroids in acute spinal cord injury. **(To access the position statement, go to www.caep.ca. Click on "Policies/Guidelines," "Position Statements and Guidelines," and scroll down to "CAEP Position Statement on Steroids in Acute Spinal Cord Injury.")**

"The working group of which I was a member critically appraised the evidence and determined that, in our opinion, based on the strength — or lack thereof — of evidence, the use of steroids in spinal cord injury should be a treatment option, not an expected standard of care for every patient," says Cass.[2]

Cass says he is not aware of any current legal actions related to not giving high-dose steroids to spinal cord injured patients in Canada. However, there have been cases in the past where physicians were sued based on the lack of administration of high-dose steroids.

"This in fact was one of the reasons for the working group examining the evidence in a critical fashion," says Cass.

High risk of complications

Emergency physicians are obligated to treat the patient using therapies based on the best available evidence at the time, says **Bryan E. Bledsoe,** DO, FACEP, clinical professor of emergency medicine at University of Nevada in Las Vegas.

"Treating the patient to meet the needs of the legal system violates many of the most fundamental tenets of medicine," says Bledsoe. "But spinal cord injuries remain a difficult area."

In the 1980s, the National Institute for Neurological Disorders and Stroke (NINDS) funded several trials evaluating the efficacy of various treatments for spinal cord injury.[3,4]

"These trials, all conducted by the same lead researcher, resulted in a fax from NINDS to emergency physicians implying that high-dose steroids administered promptly for spinal cord injury would improve neurologic outcome," says Bledsoe.

This was based upon data from the second NINDS trial, and was sent prior to publication of the results in a peer-reviewed journal. "Hospitals and physicians immediately changed their practices and began the administration of high-dose steroids for victims of acute spinal cord injury," says Bledsoe.

However, it soon became clear that there were serious methodological deficiencies in the last two of the three studies. "Despite this, the lead researcher continued to publish the results in varying venues, in various meta-analyses, and even completed a *Cochrane Review* that seemed to make steroids for spinal cord injury a *de facto* standard of care," says Bledsoe.[5]

Meanwhile, other researchers began to detail the complications they were seeing following massive doses of corticosteroids. These included delayed wound healing, an increased infection rate, and hyperglycemia.[6,7]

—continued on page 44

Key Points

Despite research showing high-dose steroids used for spinal cord injuries have a high incidence of complications, and position papers stating that this is a treatment option only and not a standard of care, ED physicians can still be sued for not administering these. To reduce risks:

- Anticipate complications;
- Consult with the neurosurgeon; and
- Use multidisciplinary clinical pathways for appropriate patients.

SPECIAL REPORT

Standards of Medical Misconduct: What are they and why are they important?

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

You may hear phrases such as "gross negligence" and "willful and wanton misconduct" stated by the media, but these terms also are important for many health providers in that they can limit liability for providing medical care. While the laws of each state differ, in general, there are several ways in which wrongful actions may be categorized. These classifications, detailed below, include: negligence, gross negligence, willful and wanton misconduct, and intentional acts.

Negligence. Failure to exercise reasonable care is considered "negligence." In the medical malpractice setting, "negligence" is synonymous with "failing to act within the standard of care." A physician who does not act as a reasonably well qualified physician would act under the same or similar circumstances is negligent and may be liable for damages if the physician's negligence caused the patient's injuries. The negligence standard is used for most medical malpractice lawsuits.

Gross Negligence. Gross negligence is more serious than negligence. Court opinions and legislation provide multiple definitions of the term "gross negligence." These definitions include:

- "conduct so reckless as to demonstrate a substantial lack of concern for whether an injury results;"[1]
- "failure to exercise slight care or diligence;"[2] and
- an "entire want of care which would raise the belief that the act or omission complained of was the result of a conscious indifference to the right or welfare of the person or persons to be affected by it."[3]

The term "recklessness" is sometimes used in statutory language and seems to equate to "gross negligence." For example, Florida's Good Samaritan Act defines "reckless disregard" as conduct that a health care provider knew or should have known, at the time such services were rendered, "created an unreasonable risk of injury so as to affect the life or health of another."[4] The statute specifically notes that the risk caused must be "substantially greater than that which is necessary to make the conduct negligent." An Illinois court decision also noted that "the difference between reckless misconduct and [negligent conduct] is a difference in the degree of the risk, but this difference of degree is so marked as to amount substantially to a difference in kind."[5]

Willful and Wanton Misconduct. Willful and wanton misconduct generally means that someone knew that an injury was likely to result from an action and, despite this knowledge, acted with a conscious disregard toward the safety of another person. Proving willful and wanton misconduct is much more difficult than proving simple negligence or gross negligence (although some courts have held that gross negligence is similar to willful and wanton misconduct).

Legal definitions of willful and wanton misconduct include the following.

- "Actual or deliberate intent to harm" or an "utter indifference to or conscious disregard for ... the safety or property of others."[6]
- Conscious disregard of another's rights, or with reckless indifference to consequences that the defendant is aware, from his knowledge of existing circumstances and conditions, would probably result from his conduct and cause injury to another.[7]
- Willful and wanton negligence, unlike gross or ordinary negligence, requires an actual or constructive consciousness that injury will result from the act or omission.[8]

Intentional Acts. Finally, an intentional act ("tort") is an act of which the outcome is known and the actor wants the outcome to occur. Assault and battery are two examples of intentional torts. The difference between willful and wanton misconduct and intentional actions is sometimes difficult to determine. Intentional acts are those that someone wants to occur, while willful and wanton actions imply that an injury was likely to occur and the person "just didn't care" what would happen.

One example of an intentional medical tort occurred when an obstetrician carved his initials into a patient's abdomen after delivering her newborn baby.[9] The surgeon knew (or should have known) that the patient would have a scar and intended to cause the scar, as was evidenced by his initials on the patient's abdomen. The hospital and physician in that case settled the lawsuit for a total of $1.75 million.[10]

Applicability. Public policy favors encouraging people to help others in need. For example, the federal government allows us to write off charitable contributions on our taxes. If the charitable tax deduction was removed, it is likely that fewer people would donate items to charity.

The same public policy arguments can be made when encouraging people to provide medical care to those in need. Every state has a "Good Samaritan" statute that limits the liability of those who help someone in a

medical emergency.[11] Were these statutes not in place, bystanders might reconsider a decision to stop and help others for fear of being sued if they did something "wrong." Similarly, states have statutes that protect "first responders" from liability when they respond to 911 calls and transport patients to the hospital. Were medics and paramedics held responsible for any perceived "negligent act" while attempting to stabilize and transport a patient, fewer people would be willing to provide such care. The ability to receive prompt care would then diminish as fewer and fewer first responders would chose to be subject to liability, and the amount of bad outcomes from the delays in medical care would increase.

However, the protection provided to Good Samaritans and first responders is not absolute. While protected from liability for negligent actions, the statutory protection generally does not apply to care that is considered "willful and wanton." One example of a court decision holding that healthcare providers had engaged in willful and wanton misconduct occurred when a patient called 911 complaining of an asthma attack; the patient told the dispatcher that she thought she was "going to die." Paramedics went to the scene, knocked on the door, and then left the scene when no one answered. Later, it was learned that the door was unlocked, that the paramedics violated basic training procedures by not attempting to open the unlocked door, and that the patient inside had indeed died from her asthma attack.[12]

First responders have been sued for delaying intubation;[13] for performing incorrect intubation (i.e., intubating the esophagus);[14] and for administration of D50 into an infiltrated IV line that ultimately resulted in an ulnar nerve injury.[15] In each case, the courts held that these errors did not amount to willful and wanton misconduct and were, therefore, nonactionable. In another case, failure to institute prompt fetal monitoring on an assaulted pregnant patient in the emergency department was not considered willful and wanton misconduct, even though the fetus eventually died from undiagnosed abruptio placenta.[16]

Medical Malpractice. Many states have realized that the public policy arguments used to protect Good Samaritans and to ensure the availability of prompt medical transport also can be used to help ensure that emergency physicians and on-call physicians continue to remain available. In the current system, specialists may simply refuse to provide on-call coverage for emergency patients rather than to risk massive malpractice judgments for treating patients whom they have never seen before, who may not pay them, who may not be compliant with treatment, and who may never be seen again. Because fewer and fewer specialists are willing to provide on-call coverage, some patients with emergency conditions are having a difficult time finding appropriate care.

For example, before a medical malpractice plaintiff can prevail in Florida, the plaintiff must prove that the physician's medical care demonstrated "a reckless disregard for the consequences so as to affect the life or health or another."[17] The statute defines "reckless disregard" as conduct that "would be likely to result in injury so as to affect the life or health of another ..."[18] One case in which a Florida court held that an on-call surgeon engaged in intentional misconduct occurred when a surgeon refused to come to the ED to drain an abscess. During his deposition, the surgeon stated that he felt "insulted" to be called in to drain a small abscess. The abscess was the focus of an infection that resulted in the patient developing toxic shock syndrome that ultimately caused her death.[19] The court held that the plaintiffs in the case were entitled to seek punitive damages against the defendants (punitive damages in Florida are only applicable to intentional misconduct).

Similarly, Georgia law currently requires that malpractice actions arising out of care provided in an emergency department or obstetrical unit must be proven "by clear and convincing evidence that the physician or health care provider's actions showed gross negligence."[20] Georgia Senate Bill 286 is currently pending in the Georgia General Assembly and seeks to amend the Georgia statute to reduce the standard of proof back to ordinary negligence.

Many state statutes also limit noneconomic damages for medical malpractice cases but do not apply those limits if the health care provider engaged in willful or wanton misconduct. Here are some examples.

- South Carolina statutes limit noneconomic damages in medical malpractice cases to $350,000 against a single health care provider, but those limits do not apply if there has been "willful negligence or misconduct" (§15-32-220).
- Alaska statutes limit noneconomic damages to $250,000 or to $400,000 for wrongful death or injuries that are more than 70% disabling; however, those limits do not apply to intentional or reckless acts or omissions (§09.55.549).
- Pennsylvania statutes allow awards of punitive damages against health care providers, but only upon proving willful misconduct or reckless disregard (§40.1301.812-A).

Note that a health care provider's knowledge is an important aspect in determining whether willful and wanton misconduct has occurred. Placing a hypotensive patient on a nitroglycerin drip might be considered willful and wanton misconduct; however, if the health care provider was a new nurse who thought that the nitroglycerin was an antibiotic, the conduct

might instead be considered negligent. Similarly, administering an antibiotic to a patient after being told that the patient has an anaphylactic reaction to that antibiotic might be considered willful and wanton misconduct, while administering the antibiotic might be considered entirely appropriate if the health care provider is told that the patient has no allergies.

Conclusion. Some state legislatures have categorized wrongful actions occurring during the medical treatment of patients into different levels of culpability to provide some protection to health care providers. By increasing the standard of proof in medical malpractice to one of willful and wanton misconduct, legislatures make it more difficult to hold health care providers liable for medical malpractice. These statutory protections reinforce the public policy that assuring providers are available to provide medical care is equally if not more important than assuring that medical care is provided "perfectly" under all circumstances. Expert witnesses who testify about the standards of medical practice should thoroughly consider the significant differences between simple negligence and willful and wanton misconduct and should never equate, or even approximate, these two standards.

Increasing the threshold for malpractice actions against on-call specialists to a standard of "recklessness" is one of the strategies that the American College of Emergency Physicians (ACEP) On-Call Task Force is considering to help ease the crisis in providing on-call care to emergency department patients. States experiencing an on-call crisis may consider whether such a statutory amendment could improve the accessibility of care for its citizens.

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Points to Remember

- ❏ Willful and wanton acts may subject a health care provider to punitive damages.
- ❏ Malpractice insurance may not cover willful and wanton acts.
- ❏ Health care providers may be subject to criminal prosecution if they have committed willful and wanton acts.
- ❏ A determination that conduct was willful and wanton depends upon the potential seriousness of the consequences and the health care provider's knowledge at the time of the incident.
- ❏ Willful and wanton misconduct is a difficult standard for a plaintiff to prove.

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The controversy resulted in the publication of position papers by CAEP and the National Association of EMS Physicians,[8] which stated that high-dose steroids for acute spinal cord injury is a treatment option only, and not a standard of care.

Subsequent research has confirmed the high incidence of complications following steroid administration, occurring in up to 87% of patients with complete spinal cord injury receiving steroids in one study.[9] However, a Japanese study has indicated that there may be some benefit in patients with incomplete cord injuries.[10]

"Thus, clinical practice should be based upon the evidence available," says Bledsoe.

The massive dose of steroids used in the NINDS protocol has numerous documented adverse effects, says Bledsoe. "These primarily are infection, severe pneumonia and sepsis, delayed wound healing, and hyperglycemia," he says. "The length of hospital stay is longer for patients who receive steroids — 44.4 versus 27.7 days in one study. Fatal complications have been reported."[11]

The prevailing national standard of care for acute spinal cord injury is primarily emergent medical stabi-

lization followed by appropriate surgical stabilization, says Bledsoe.

It is Bledsoe's opinion that "the use of high-dose steroids probably should only be considered in patients with incomplete lesions who do not have confounding medical or surgical conditions that would be adversely affected by steroids," he adds.

Regardless, complications from high-dose steroid administration have a high incidence and must be anticipated. "The decision to administer steroids to the victim of an acute spinal cord injury should be made only following consultation from the neurosurgeon who will be subsequently managing the patient," says Bledsoe.

The devastating impact of a spinal cord injury is a factor in the outcome of ED malpractice litigation. "Most juries will feel sorry for a spinal cord injury victim and rule based upon emotion and not the evidence," says Bledsoe. "This is complicated by the fact that the science in this area is quite complex and quite controversial."

The 2007 spinal injury of Buffalo Bills football player Kevin Everett was closely followed by the public, notes Bledsoe. Three components of Everett's treatment have been the source of considerable discussion in the media: Care on the field by emergency medical services and trainers, induction of hypothermia, and administration of high-dose steroids.

Everett reportedly had an incomplete lesion at the C4 level. "His recovery appears to be better than typically seen — although the reason remains unclear," says Bledsoe. "However, media coverage of the event may put undue pressure on emergency physicians to use empiric steroids when confronted with an acute spinal cord injury."

ED medical directors should proactively meet with neurosurgical staff and plan an evidence-based treatment strategy/clinical pathway for these devastating injuries, advises Bledsoe. "Multidisciplinary clinical pathways applied routinely to appropriate patients indicate a local standard and can aid in risk management," he says. ■

Sources

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How can "standard of care" affect a lawsuit?

The "standard of care" often has a significant impact on the outcome of ED malpractice lawsuits, but the way this is defined can vary according to state law and other factors.

"The suit often will come down to competing interpretations of the applicable standard of care," says **Erin McAlpin Eiselein,** a partner at Davis Graham & Stubbs in Denver, CO. "Generally, expert testimony is necessary to prove the applicable standard of care."

In most U.S. jurisdictions, the rule is that the ED physician should exercise the degree of skill and diligence exercised by others in his/her specialty under the same or similar circumstances.

"In theory, a doctor who has done that, whatever it consists of, has complied with the standard, and need do no more," says **Joseph P. McMenamin,** a partner at Richmond, VA-based McGuireWoods. "Whatever the outcome, even if it is very bad, he is not liable and has not committed malpractice."

The term "standard of care" is generally defined as the degree of care and skill used by an average practitioner in the defendant's specialty. "It is an objective standard, and so the physician's intent or good faith is irrelevant to the inquiry," says Eiselein.

There is no universal standard of care, because the determination is comprised of a variety of factors, including the doctor's specialty, the present state of medical knowledge, and available resources. "Physicians are always held to a minimum level of professional competence. So if customary practice is negligent, a physician following only that minimal standard may face liability," says Eiselein.

A good example of how important the standard of care can be to the outcome of a lawsuit is found in a Louisiana malpractice case, where the jury was asked to decide whether an ED physician's failure to administer heparin to a patient presenting with unstable angina violated the standard of care.[1]

Even though a cardiologist offered expert testimony for the plaintiff that heparin was standard procedure at that time, two expert ED physicians disagreed and testified that heparin was not the standard of care for emergency physicians.

"In the end, the jury sided with the emergency department experts and concluded that the physician did not violate the standard of care, and therefore did not commit malpractice by failing to administer heparin," says Eiselein.

Key Points

The outcome of ED malpractice lawsuits often depends on the fact-finder's estimation of the reliability of competing interpretations of the standard of care, as characterized by expert witnesses. Some factors that come into play:

- The ED physician must exercise the degree of skill and diligence exercised by others in his/her specialty under the same or similar circumstances at the time the case arose.
- Standard of care depends on the doctor's specialty, the present state of medical knowledge, and available resources.
- Evidence such as new research is not admissible if it was not available at the time the care occurred.

The way care is compared varies

The court will ask the "finder of fact," usually a jury, to compare the care the defendant doctor provided with care that other doctors provide in similar circumstances.

"The frame of reference for the comparison that must be made varies with state law," says McMenamin. States may compare the conduct of the physician-defendant with that of practitioners of the same specialty in the United States, within the state, or within the same or similar communities.

For example, an ED physician is required to use high-dose steroids only if other reasonably prudent members of that specialty would not fail to use them. "If there is no blanket rule, and reasonably prudent members of the specialty would use high-dose steroids in some spinal cord injuries but not others, then as long as the doctor-defendant was not caring for the kind of cord injury where the standard required use of steroids, he is not required to use them," says McMenamin.

"Lawyers and judges do not presume to tell physicians how to practice medicine," says McMenamin. "The law recognizes that physicians are uniquely qualified to determine what kinds of care are called for in any given clinical situation. Lawyers and judges, however learned, are not."

Instead, the law asks the medical profession to state what rules govern its conduct, and its members are then held to those rules. "So how is a lay jury or judge supposed to know what is required in a particular clinical situation? By listening to the testimony of expert witnesses," says McMenamin.

The plaintiff will call someone who claims, by virtue of his knowledge, training, skill, and experience, to know what reasonably prudent doctors in the specialty do under analogous circumstances, he says. Assuming the court agrees that he is indeed qualified, the expert will offer his opinion on the subject.

The defense also is permitted to offer expert testimony, which typically contradicts the testimony offered by plaintiff's expert. "The finder of fact is authorized to decide which of the two it believes," says McMenamin. "And on that basis, it decides whether the care was standard, and hence not actionable, or not."

The doctor must be judged by the state of medical knowledge as it stood at the time of the care complained of. If new research on high-dose steroids was published a month ago, and the care being scrutinized took place two years ago, then the evidence is not admissible.

Conversely, new evidence might have come out two years ago, while the care took place only a week ago. "A finder of fact might well be willing to agree with the plaintiff that two years is enough time for the doctor to have gotten the message, so he was not justified in providing outmoded care last week," McMenamin says.

However, the defense might demonstrate that even though a paper came out two years ago challenging the use of steroids, other more recent papers contradict that finding, and that many prudent physicians continue to use high-dose steroids despite the criticism of the practice in some circles. "If the fact finder agrees, the defense will win," says McMenamin. ■

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EM group might be liable for physician misconduct

If an emergency physician is arrested for assaulting a patient or for inappropriate sexual conduct, there is potential liability exposure for both the emergency medicine group and the hospital where the ED is located, says **Thomas H. Taylor**, a health care attorney at LaCrosse, WI-based Johns, Flaherty & Collins.

The hospital faces potential liability for negligence in the credentialing and privileging process if it knew or reasonably should have known that the physician in question presented a risk of harm to the patient.

Whether liability exists for an emergency medicine group depends on how the group is structured, whether the physician is an employee or an independent contractor, the scope of the group's insurance coverage, and any contractual indemnification provisions that might exist, says **Scott A. Edelstein,** a health care attorney with Washington, DC-based Squire, Sanders & Dempsey.

The emergency medicine group is subject to potential liability on one of several theories:

• Negligent hiring, if the group failed to exercise reasonable care in performing employee reference checks and assessing the physician during the hiring and employment process.

Before hiring new emergency medicine physicians or locum tenens, verify their credentials, check their references, and engage in reference checks with hospitals where they have had emergency medicine and other privileges, advises Taylor.

In one case, a hospital was found not liable for the negligent hiring of an employee who was accused of sexually assaulting a patient.[1] "The New York Court of Appeals determined that the hospital acted with reasonable care in hiring and supervising the employee and that its management did not authorize, participate in, consent to, or ratify the employee's alleged conduct," says Edelstein.

• Negligence, if the group knew or should have known about the risk of a sexual or other assault upon a patient, based upon the physician's past conduct in the workplace and elsewhere.

• *Respondeat superior*, or vicarious liability, if the physician was acting within the scope of his or her employment when he or she sexually or otherwise assaulted the patient.

"Although it is hard to comprehend any circumstances when such a physician would be deemed to have acted within the scope of his or her employment at the time, some courts have evaluated that issue primarily from the perspective of a patient," says Taylor.

If the patient was receiving care in the ED and the physician crossed boundaries and engaged in inappropriate conduct, some courts have held the physician group liable on a *respondeat superior* theory.

Taylor has acted as legal counsel in advising and representing physicians and physician practice groups accused of engaging in inappropriate conduct, including one case of an emergency medicine practice group sued on a *respondeat superior* theory after a physician inappropriately touched and fondled a patient.

Take action if accusations are made

If allegations are made against an emergency physician or other staff member, carefully and thoroughly investigate those allegations. "If they are founded, take appropriate disciplinary action, up to and including termination of employment," says Taylor. "If the allegations are unfounded, communicate with the patient and, in addition, caution the physician about the need to be more sensitive about the manner in which his or her conduct can be misperceived."

Taylor also has represented emergency medicine physicians who have been falsely accused of engaging in inappropriate conduct during pelvic examinations. To avoid allegations of misconduct in this kind of situation, engage in a full informed consent discussion with

Sources

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the patient beforehand to ensure that the patient understands and agrees to the examination, and always have a nurse or other member of the patient care team in the room to witness and document the manner in which the examination occurred, he advises.

It is not unusual for physician contracts and personnel policies and procedures to permit the group to suspend a physician pending the outcome of the investigation, says Edelstein.

The group should discipline the physician for verified actions according to its personnel policies and procedures. "These policies and procedures should address the imposition of sanctions against any personnel for impermissible behavior," says Edelstein.

However, the mere fact that the physician has been arrested or accused of improper behavior does not mean that he or she is guilty. "The determination of guilt for the alleged assault can only be made by a court," says Edelstein. ■

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CNE/CME *Questions*

16. Which is recommended to reduce liability risks regarding administration of high-dose steroids for patients with spinal cord injuries?
    A. Have ED protocols state they should not be used because there is no evidence of their effectiveness.
    B. Avoid them even for patients with incomplete cord injuries because of the risk of fatal complications.
    C. Give high-dose steroids to all spinal cord injured patients, because the treatment is considered to be standard of care.
    D. Make the decision in consultation with the neurosurgeon who will care for the patient.

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17. Which would result in liability for the ED physician because he or she was not practicing according to the standard of care?
    A. The ED physician fails to adhere to new guidelines that were published after the care being scrutinized.
    B. The ED physician uses a treatment that members of the defendant's specialty would never use, and it harms the patient.
    C. The ED physician does not use a treatment which some, but not all, reasonably prudent members of that specialty would use.
    D. The ED physician fails to give a treatment which all members of the specialty would use, but the patient is not harmed.

18. Which is true regarding liability risks if an emergency physician is arrested for assaulting a patient?
    A. The hospital cannot be held liable.
    B. The emergency medicine group can be held liable for negligent hiring if reasonable care was not taken in performing reference checks.
    C. The emergency physician should never be suspended pending the outcome of an investigation.
    D. The emergency medicine group will always be liable because the physician was acting within the scope of their employment.

Answers: 16. D; 17. B; 18. B