



ED LEGAL LETTER™

THE ESSENTIAL RESOURCE FOR EMERGENCY MEDICINE MALPRACTICE PREVENTION AND RISK MANAGEMENT

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ED Peer Review Information Can Land in Plaintiff Attorney's Hands

Is an ED reviewing data on unplanned return visits, patient complaints, or complications as part of the department's peer review process? If an EP comes out of a meeting and carelessly leaves documents out in the open, this carries important legal implications. "It is now no longer protected," explains **Rick Sheff**, MD, chief medical officer at The Greeley Company.

The same is true if an EP attends a peer review meeting about a colleague and explains to an ED nurse what was covered. "The information the nurse has heard is now outside of peer review protection," Sheff warns.

These seemingly harmless actions by ED staff open the door for plaintiff attorneys to obtain peer review materials that otherwise would be protected from discovery. "People handle confidential peer review carelessly and cavalierly all the time," Sheff adds.

Laura Walker, MD, consultant for the department of emergency medicine at Mayo Clinic and emergency medicine quality chair for Southeast Minnesota

Mayo Clinic Health System, warns that if the ED's peer review process is not "rigorously managed," the information discussed may be legally discoverable.

"Understanding when and with whom you can safely discuss the case under review, and being vigilant to limit your conversations to these protected conversations, is the first and most important rule of thumb," Walker explains.

One thing is certain: The ED defense team will face a hard battle to protect every piece of peer review information. In Sheff's experience, "Every plaintiff attorney worth their salt will do everything they can to get their hands on any and all peer review information. They will push, and push hard." To increase the likelihood that peer review information is protected from discovery, EDs can take the following steps:

- **Conduct investigations in a way that maximizes existing peer review protections.**

If a hospital risk manager conducts an assessment of an adverse outcome in the ED, for instance, the report isn't necessarily protected from discovery.

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Michael R. Callahan, JD, a partner at Katten Muchin Rosenman in Chicago, says, "You can't just take a document that was produced for a different purpose, run it through a peer review committee, and claim it's protected." However, there's a simple fix: "If it was prepared at the request of the peer review committee, it is protected," Callahan says.

• Know the exact language of the state's statute on peer review, and stay current with case law.

Every state has enacted legislation that protects peer review information from discovery, but the protections are not all the same. "All 50 legislatures have recognized that it is a public good for physicians to measure each other's performance and hold each other accountable," Sheff says. "The challenge is that there are 50 different laws."

These vary as to whether peer review information also can be used for other types of performance improvement, such as patient satisfaction or ED throughput. "In some states, you lose protection when you use the same data for peer review for other purposes," Sheff explains.

The degree of protection also varies by case law. This is ever-evolving, sometimes to the detriment of EP defendants. "There are states, like Kentucky, where case law has gutted the protection of peer review information," Sheff notes. "In Florida, a state constitutional amendment has virtually destroyed peer review protection."

Courts tend to technically interpret state peer review statutes. This underscores the importance of EDs staying current with case law, and adjusting policies accordingly. Callahan warns, "If you don't come into full compliance and it's a bad case, the court will find a way to argue that the protections don't apply."

• Train staff how to express concerns so they fall under peer review protection.

If someone in the ED makes an offhanded negative remark about a colleague, it could lead to serious legal repercussions. "One thing you don't ever want to do is say something bad about a fellow practitioner in front of a patient or family," Sheff warns. "That is a setup for triggering a lawsuit."

If someone files a lawsuit, the incriminating comment won't be protected from discovery. This means a plaintiff attorney can use it as evidence that the hospital knew about an EP's performance problem and did nothing about it.

However, if the concern is addressed in a formal incident report, it's likely to be protected. "Those can be designed to be part of the peer review process, and can be handled in a confidential way by risk management," Sheff offers.

EDs face somewhat greater challenges with peer review protections than other areas in the hospital, in Sheff's view. This is because a relatively small team works closely with one another, with information often exchanged informally. "Those kinds of open, collegial relationships can create a problem for protecting peer review information," Sheff explains.

• Ensure the medical staff's peer review policy clearly defines what the organization considers to be peer review.

"Then you can very clearly point to the language, and say, 'That's what we call peer review,'" Sheff says.

When a set of activities is defined as peer review, documents that are generated and conversations that happen as part of those activities are covered by whatever protection the state provides. "But if it happens outside of those activities, there is no

protection,” Sheff adds.

• **Understand what’s protected if ED groups conduct internal peer review.**

More ED groups are conducting their own peer review instead of relying solely on the hospital to perform the task. One reason is the increasing emphasis on quality metrics and outcome measurements. “The problem is, those peer review efforts might not be protected under state law,” Callahan warns.

Some large ED groups cover multiple states. Not all have peer review protections that apply to physician groups. This means that if a bad outcome occurs and a patient sues, the hospital’s peer review materials would be protected, but the ED group’s would be discoverable. “Anything the ED group is creating could be subject to discovery in a medical malpractice case, either against the EP, the hospital, or the group,” Callahan says.

However, if the ED group’s peer review was conducted under the auspices of a Patient Safety Organization (PSO), it might be protected. Not all ED groups take advantage of this. “We are not finding ED groups participating in PSOs, even though it’s available to them,” Callahan notes.

Under the federal Patient Safety and Quality Improvement Act of 2005, all licensed providers, including EPs and groups, can claim important privilege protections from discovery

EXECUTIVE SUMMARY

ED peer review materials can end up being discoverable during malpractice litigation, if requirements aren’t closely followed. To prevent this:

- conduct investigations in a way that maximizes existing peer review protections;
- know the exact language of state statutes, and stay current with court rulings;
- instruct staff to share safety concerns in a way that ensures they’re protected.

in all state and federal proceedings relating to patient safety activities, such as peer review data, information, analyses, and reports, if they contract with a federally certified PSO.

Relying solely on the hospital for peer review is problematic for ED groups for other reasons. “If I’m a hospital interviewing different ED groups, I’m going to ask questions like, ‘What do you do internally to track adverse outcomes?’” Callahan says.

Hospitals want to know that ED groups have created good internal processes to identify risk-prone EPs. “Hospitals will say, ‘To the extent you have a problem with an EP who is working at our facility, we need to know about it. We may not want the EP here if he or she is exposing us to liability,’” Callahan says.

If a plaintiff attorney discovers an EP experienced problems at another facility, but the ED group took no action, this could open the door for the ED group to be named as a defendant.

During depositions, leadership of the ED group will face such questions as: “You didn’t do your own review of the EP? He had a problem at another hospital and you had no idea? Are you telling me you don’t do anything to track your own physicians’ performance?”

“The plaintiff attorney could allege that had the ED group taken action, the patient would not have been injured,” Callahan says. ■

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Is Your ED Patient Now a Plaintiff? Long Legal Battle Might Be Avoidable

Upfront meetings save both sides time and expense

In typical malpractice litigation, the first chance EP defendants get to explain the care they provided comes during their deposition — and they know full well that every word can be

used against them in court.

“By the time that comes out, everyone is so invested in the litigation — and the patient is so angry at being ignored — that any chance of resolving

the case is significantly diminished,” says **Brandon K. Stelly**, vice president of enterprise risk management and internal counsel at Schumacher Clinical Partners, a Lafayette, LA-based

emergency medicine group.

Schumacher Clinical Partners routinely meets with patients, family, and attorneys as early as possible when a malpractice claim is filed. “When we get a claim we believe is defensible — and even for some that are less defensible — we immediately engage plaintiff counsel in discussion,” Stelly explains.

The group makes a simple, but surprising, offer to the opposing counsel: Let’s all sit and talk openly about the care that was provided in the ED. “We’re a little unorthodox in that approach,” Stelly notes. “Litigants in general tend to hide behind their attorneys and use them as mouthpieces.”

Few plaintiff attorneys refuse the offer to sit and talk. “When we sense trepidation, we will often offer a list of names of other plaintiff attorneys in the state, so that the uneasy attorney can contact them to confirm our intentions are genuine,” Stelly says.

Talking about the strengths and weaknesses of the malpractice claim is often eye-opening for both sides. “That front end conversation at least has the effect of letting everyone fine-tune their cases, to take some age off of the litigation process,” Stelly says.

Protracted litigation leads to skyrocketing costs on both sides. “What you could have settled for \$10,000 back on day 21 is now going to cost you \$110,000 to settle on day 601, because everybody’s invested time and money in the case,” Stelly says. Here

are some of the benefits resulting from the group’s meetings:

- **The group is able to explain why the ED care was appropriate.**

“We do this in a respectful manner because somebody is doing this because they are upset,” Stelly notes. In some cases, there is a good reason why the EP was unable to make the correct diagnosis at the time of the ED visit, or why a particular treatment was not appropriate at that point in time.

“Many claims are filed because of a lack of understanding. Those tend to be the ones that people deem to be frivolous,” Stelly says.

At times, a candid discussion about the medicine and the EP’s thought process has resulted in a voluntary dismissal of the claim. “But more importantly, and much more frequently, there are many instances when it has resulted in a claim not being filed,” Stelly adds.

There always will be claims in which there is a genuine difference of opinion. In those cases, Stelly says, “we very politely debate the medicine, and whether it was reasonable or unreasonable.”

The plaintiff sometimes realizes that no negligence occurred on the part of the EP, and agrees not to oppose a summary judgment filed by the defense attorney. “Sometimes, a guy who wanted a million dollars will suddenly take a cost of defense settlement or cost reimbursement,” Stelly says.

An outright voluntary dismissal of the claim against the EP is harder to come by. “But if we have that conversation early on, and explain why the case is so defensible, every once in a while it results in the case going away,” Stelly offers.

- **The group is able to correct misconceptions held by the plaintiff attorney.**

On several occasions, the plaintiff attorney didn’t realize he or she had to meet a “gross negligence” standard to prevail, because of newly enacted tort reform legislation in their state. “It affords us the opportunity to say, ‘Hey, did you know this is what you have to prove?’” Stelly says. At one such meeting, the patient’s attorney said it would take \$6 million to settle the case — in a state that capped damages at \$500,000.

Sometimes, factors that have nothing to do with the facts of a particular case. “You shouldn’t be scared of any given courtroom,” Stelly notes. “But there are certainly jurisdictions that are much more dangerous to try a case as a defendant.” Thus, the venue factors into decision-making.

- **The plaintiff attorney is able to explain why he or she believes there is a strong case against the EP.**

If an ED claim is a strong candidate for settlement, it’s better if both parties know sooner rather than later. “They will come back and say, ‘But did you realize this?’ We sometimes are given a piece of new information that helps us all, including the EP, evaluate just how much risk we have,” Stelly says. ■

EXECUTIVE SUMMARY

By meeting with plaintiffs and attorneys, Schumacher Clinical Partners reduces protracted ED malpractice litigation. Claims against EPs are dropped occasionally after the care is fully explained; in other cases, the settlement process is expedited.

- EPs discuss their medical decision-making.
- Defense attorneys explain why a case is defensible.
- Plaintiff attorneys share information on the strength of their case.

SOURCE

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Was ED Patient at Fault for Bad Outcome?

Subtle Approach Often Is Best Defense Strategy

Did an ED patient's own actions contribute to a bad outcome? It's tricky for the defense to bring this up during malpractice litigation.

"It can appear as though the emergency physician is now criticizing the injured patient. This can be detrimental to a case tried before a jury," explains **Mallory B. Earley, JD**, a risk resource advisor at ProAssurance in Birmingham, AL.

Sean P. Byrne, JD, a medical malpractice defense attorney in the Glen Allen, VA, office of Hancock, Daniel, Johnson & Nagle, agrees: "It's always potentially dangerous to blame the ED patient. There is a power imbalance, and the jury sees that." If a malpractice case against an EP has gone to trial, odds are that the patient suffered some type of catastrophic injury. "The jury will feel sympathy for them," Byrne says.

Subtle Approach Is Best

Most states use a comparative fault system. This means that if the ED patient carries some degree of responsibility for the adverse outcome, recovery declines apportionately.

Byrne practices in one of the few states that adhere to a strict contributory negligence doctrine. "If the patient is at fault, they get zero recovery. That seems really harsh, so courts are very reluctant to authorize that defense," Byrne says.

Further complicating the use of the defense: The patient has to be negligent at the same time the physician is, and has to be a proximate cause of their injury. This is rarely, if ever, the case. "Instead, a lot of times that notion is pursued as a mitigation

of damages defense," Byrne says.

Alabama also uses a contributory negligence doctrine. Earley explains that to use this defense, the EP faces the difficult task of proving that the patient had knowledge of a dangerous condition, appreciated that danger, and failed to care for his or her own safety.

Attorneys often use a subtler approach. The defense can point out the ED patient's actions without specifically pleading a contributory negligence defense. "This allows the defense attorney to connect facts alluding to contributory negligence, but stop short of having the burden of proof," Earley explains.

Defense attorneys can express compassion for the patient's injury while asserting strongly that it was not the EP's fault. "We raise it more subtly — not as a legal argument," Byrne notes. "We want to avoid offending the jury by blaming the patient." Byrne typically explains to juries that both the EP and the ED patient have responsibilities. Here are some scenarios the defense can use to mitigate the EP's liability:

- **The patient didn't provide a complete and accurate history.**

"This happens occasionally with

ED cases," Byrne says. This can be significant in malpractice litigation, since the chief complaint, history, and symptoms form a critical part of the EP's differential diagnosis.

Byrne tells juries that the EP relies on the patient to give good information. "The decision-making in the ED is only as good as the information it is based on," he says. A patient's failure to offer full and complete relevant information can mitigate the EP's liability — but it's hard to prove it without good documentation.

"Sometimes, the patient claims they did tell the EP certain things, and the EP just failed to document it," Byrne offers. An ED chart that is sparse and incomplete hinders the defense's ability to counter this allegation.

"Expressed pertinent negatives are better than charting by exception," Byrne warns. In other words, it's better if the EP documents "recent fall, no loss of consciousness" than simply "recent fall." Otherwise, it leaves open the possibility that the EP was told the patient had lost consciousness but failed to include this important information in the ED chart.

"If the EP says, 'Trust me, if it's not

EXECUTIVE SUMMARY

It is challenging for defense attorneys to argue that an ED plaintiff's own actions — leaving against medical advice, failing to follow up, or giving an inaccurate history — contributed to a bad outcome. Some effective approaches:

- Avoid the appearance of criticizing an injured patient.
- Point out ways in which the patient contributed to the harm, without specifically pleading a contributory negligence defense.
- Express compassion, but assert strongly that it was not the EP's fault.

there in the chart then the patient didn't tell me,' the plaintiff attorney always flips it back," Byrne adds.

• **The patient failed to follow up or return to the ED as instructed.**

"With any delayed diagnosis claim, typically the longer the delay, the worse the harm alleged," Byrne says. If the patient failed to obtain recommended outpatient evaluation, he explains, "some portion of that delay then becomes the fault of the patient."

Clear documentation of discharge instructions can help the EP's defense. Earley says, "If the patient were to not follow these documented instructions, this would be evidence of non-compliance and potentially contributory negligence."

If the patient didn't return to the ED as instructed, timing becomes important. Byrne explains, "If the patient testifies that their symptoms worsened, the defense pinpoints if there was a delay between the time they noticed the failure to improve and when they returned to the ED."

Adrienne M. McFadden, MD, JD, FAAEM, FACEP, FCLM, a former EP at EMP in Charlotte, NC, says if the ED chart clearly documents follow-up instructions and the patient understood these instructions, "that is a very valuable tool for defense in malpractice cases."

In McFadden's experience, EPs document follow-up instructions well. What they often omit is that the patient understood these, such as "patient was able to repeat back the instructions."

"That is not often utilized, but it can be a valuable sentence that bolsters the chart," McFadden says. EPs can ask questions such as "Can you explain what you will do if your pain increases?" and then document the patient's response.

• **The patient left the ED against medical advice (AMA).**

Earley notes that the Supreme Court of Alabama found that an "assumption of risk" defense was appropriate when a patient left an ED after being told that "[he] could die"

without proper treatment.¹ "After discharge, a laboratory value for this patient indicated he was in diabetic ketoacidosis and, subsequently, the patient died," Earley says.

The case shows why an AMA form should include specifics about the actual patient's condition and what could happen without treatment, says Earley, "as opposed to generic possibilities." ■

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Plaintiff Attorney Added EMTALA Claim to ED Malpractice Lawsuit

Jury awarded plaintiff \$1.45 million in punitive damages

A homeless man presented to an ED twice in 18 hours, complaining of severe pain, and died of a ruptured ulcer a few hours after the second discharge.¹

The family sued for malpractice, and the plaintiff attorney also alleged an Emergency Medical Treatment and Labor Act (EMTALA) violation. A jury awarded the plaintiff \$25,000 in compensatory damages and \$1.45 million in punitive damages.

The plaintiff alleged that the hospital failed to stabilize the patient as required by EMTALA. The dece-

dent's family brought suit against the hospital, along with several EPs and ED nurses.

"EMTALA permits the recovery of damages obtainable for personal injury under the forum state's law. In some states, adding an EMTALA claim can make a lot of sense," explains **Timothy C. Gutwald**, JD, a healthcare attorney in the Grand Rapids, MI, office of Miller Johnson.

In this case, the recovery of punitive damages in connection with the EMTALA claim was governed by Kentucky law. The patient's consistent

complaints of severe pain and return trips to the ED were key factors in both the malpractice and EMTALA claims. "It appears that the plaintiffs had a strong malpractice claim," Gutwald notes.

The Kentucky Court of Appeals noted that under EMTALA, a plaintiff may "obtain damages available for personal injury under the law of the state in which the hospital is located."

Including an EMTALA claim doesn't usually lead to bigger awards than would be obtained in a regular malpractice case, Gutwald notes. "But

it does seem that the jury and court of appeals were particularly appalled by what happened here,” he says. “I think the EMTALA violations were a key factor in the jury’s punitive damages award.”

Gutwald adds, “Anytime a plaintiff attorney sees only a cursory screening exam, or no screening exam at all, it makes sense for him or her to think about adding an EMTALA viola-

tion.” The same is true if it appears as though the patient wasn’t stabilized prior to transfer or discharge. A jury may view those actions as patient dumping.

“As the large punitive damage award shows, juries strongly disapprove of any attempt to dump a difficult patient,” Gutwald concludes. “This is particularly true if the patient is part of a vulnerable population.” ■

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Consultant Refuses to See ED Patient? Legal Risks Exist on Both Sides

In the face of push-back from an on-call consultant, EPs should consider both the Emergency Medical Treatment and Labor Act (EMTALA) and hospital bylaws, says **John W. Miller II**, principal at Sterling Risk Advisors in Atlanta.

EMTALA is clear that the on-call physician must defer to the medical judgment of the EP who has personally examined the patient, Miller notes.

“If you are making a judgment from afar, and the EP tells you, ‘I think you really need to see this patient and attend to their needs,’ you don’t want to be the consulting physician who refused,” Miller explains.

During medical malpractice litigation, the plaintiff attorney can put this question to the on-call physician: “Why didn’t you listen to your colleague who called you?”

“How are you going to explain yourself?” Miller asks. “That’s a really tough place to be.”

Miller advises hospitals to implement bylaws that reflect exactly what EMTALA requires, and no more. “To create a requirement over and above EMTALA raises the stakes in litigation,” he explains. “Why

create a higher standard than is imposed on you by federal law?”

Miller says the safest course is to simply state that consultants should defer to the judgment of the EP, who has actually seen and evaluated the patient. “This is the prudent risk management technique for everyone involved — the EP, the consultant, and the hospital,” he adds.

In malpractice cases in which on-call physicians have refused to come to the ED, Miller adds, “there have been tremendous repercussions for the on-call physician.”

Ultimately, it’s the specialist’s decision whether to come to the ED to personally evaluate any patient he or she is called about. **Catherine Vretta**, MD, MPH, an EP at Ascension St. John Hospital in Detroit, says, “But the EP should definitely document any circumstance

in which they requested the specialist to evaluate the patient, if the specialist refuses.”

One exception is if the on-call physician asks to see the patient in his or her office because diagnostic equipment is available that the hospital doesn’t have. “If you can make that case, there are some carve outs to EMTALA that allow the ED patient to be referred directly to the office,” Miller notes. “But those cases are few and far between.”

To avoid conflict, EPs don’t always insist the consultant come in. Some don’t do anything about the refusal, other than document it.

“This is a two-fold problem,” Miller says. “First, it doesn’t absolve the EP of their responsibility for the patient.”

The second problem is that it exposes the hospital to liability.

EXECUTIVE SUMMARY

EPs sometimes are faced with on-call consultants who are reluctant to come in to see the ED patient, exposing the EP, the consultant, and the hospital to liability. Some strategies:

- Ensure that hospital bylaws reflect exactly what’s required by EMTALA.
- Require consultants to defer to the EP’s judgment.
- Inform consultants that the refusal is being documented.

“Documenting in the record, and then not following through with the escalation process, increases the likelihood that the hospital is brought into the litigation,” Miller explains.

The care episode would have otherwise involved only the two providers and their alleged negligence, Miller says. The fact that the hospital bylaws weren’t followed opens the door for the plaintiff to bring the hospital into the litigation.

Miller recommends that EPs inform the consultant that they’ll document the refusal, and that they will follow whatever protocols are in place to address the issue. “In the vast majority of cases, the consultant will come in. They don’t want to subject themselves to that,” Miller says.

This is, of course, likely to create some tension between the ED and on-call consultants. “But the appropriate place to work that out is at a medical staff meeting, not during a 2 a.m. phone call,” Miller says.

Document Conversation

Vretta says the EP should document clearly in the record the time the specialist initially was called and the time the specialist responded. “These may be vastly different,” she says. “In many hospitals, a paging

system or electronic contact system can document these times.”

In addition, Vretta says the EP should document:

- a description of the patient’s problem, as well as the patient’s condition at the time of the conversation;
- any concerns the EP has;
- exactly what the recommendations of the specialist were.

Documentation showing the EP’s frustration with the consultant’s responses is not helpful, according to Vretta. “It may imply the EP was more focused on their frustration than on the actual patient,” she says. “If multiple calls and repeated pages are documented, the chart will speak for itself.”

In Miller’s experience, the ED chart is usually more complete than what the on-call consultant has documented. The consultant might be taking the call at home in the middle of the night, whereas the EP is documenting concurrently during his or her shift.

“However, it’s always the one fact that the case turns on that inevitably is not documented by the EP,” Miller says. He likes to see as complete a record as possible of the conversation between the EP and the consultant.

“I have had some cases where I

would have loved to have the actual record of the conversation, because it would have meant the successful defense of my EP who was following the consultant’s recommendations,” Miller says.

The EP should share the right level of data to allow the consulting physician to assist in the patient’s care. “EPs who have lived through litigation learn pretty quickly the appropriate level of information to convey,” Miller says. “Really, what we are talking about is appropriate communication between professionals.”

Clear documentation of what was said by both parties is not only good medicine, it is a good legal defense. “Just as you document conversations with patients, it is of equal importance to document conversations with your colleagues,” Miller advises. ■

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Malpractice Outcome Could Hinge on What ED Nurses Documented

Charting by ED nurses is issue ‘in almost every case’

ED nurses documented a 46-year-old woman’s chief complaint as: “Chest pain. Pain from above waist to head, neck, and arms.” The ED’s discharge diagnosis, in contrast, was “hypertension and bronchospasm.”

The patient died the following day

of a heart attack. “It’s a classic example of how the provider didn’t get the question the patient was asking: ‘Am I having a heart attack?’” says **Michael B. Weinstock**, MD, adjunct professor of emergency medicine at The Ohio State University Wexner Medical

Center. “If the provider had simply read the nursing documentation and attempted to answer the question, the outcome may have been different.”

The outcome of many a malpractice lawsuit has turned on something an ED nurse documented. “ED

nursing documentation comes up in almost every case. Vital signs are sometimes the only objective data in a chart replete with subjectives,” says **Robert Broida**, MD, FACEP, director of U.S. Acute Care Solutions’ risk management department and COO of Physicians Specialty Ltd.

For an EP defendant, Broida says a confirmatory nursing note is “golden. Juries may not sympathize with a physician, but everyone loves nurses.”

Yet many EPs don’t read nursing notes at all, Weinstock says. Electronic medical records (EMRs) are a common obstacle. “The problem is there is such a tremendous amount of information, it’s almost an impossible task to get through it,” Weinstock explains.

Some EMRs put the nursing documentation in a different area than the EP uses for his or her documentation. Thus, the EP might see the patient’s chief complaint of headache as documented by the triage nurse, but might not see additional ED nursing notes stating that the patient has a fever and reported exposure to someone with meningitis. If the patient ends up with a missed meningitis diagnosis, the plaintiff attorney can point out that the information was available to the EP, but was ignored.

After such a “divided EMR” case was reported, Broida’s group developed an ED nursing policy that requires nurses to verbally communicate any abnormal vital sign to the EP. Nurses automatically re-check any abnormal vital signs in 30-60 minutes. “This overcomes the new EMR technologic hurdle with good, old-fashioned, direct communication between team members,” Broida says.

To sign off on a chart, some EMRs require EPs to click a box that reads, “Nursing note reviewed and I agree with assessment.” **Jesse K. Broocker**, JD, an attorney at Weathington Mc-

EXECUTIVE SUMMARY

ED nursing documentation frequently becomes an issue in malpractice litigation against EPs. Some risk-reducing strategies:

- Create ED policies requiring nurses to verbally communicate any abnormal vital sign to the physician.
- Require EPs to obtain additional information from nurses or the patient before the patient leaves the ED.
- Mandate triage nurses to ask patients, “What is the main concern you have today?”

Grew in Atlanta, says, “If it is there to be gleaned from the chart, you can bet the EP will be asked about why they did not avail themselves of that information. We always prepare our EPs to answer that line of questioning at deposition or trial.”

There is “almost always” some finding in a nursing note that is relevant to a diagnosis the plaintiff attorney claims the EP missed, Broocker notes. In one case, the patient’s mental capacity at the time of the evaluation was in issue. The EP had documented that the patient appeared alert and oriented, but a nursing note stated, “Patient appears intoxicated and is slurring words.”

“Plaintiff counsel spent a lot of time asking about that note and then arguing that we should have known about it,” Broocker says.

Address Conflicts Directly

If the ED nurse documents something concerning, the EP needs to “address it head on,” Weinstock says.

“Every experienced EP will say they’ve been saved by an ED nurse who offered information that the patient didn’t tell to the EP,” he notes.

Weinstock recommends conducting a “hard stop” with medical decision-making after the EP has

addressed the patient’s main concern. “If your evaluation and documentation do not flow in a logical manner, go back and get additional information before the patient leaves the ED,” he says. ED patients frequently report other symptoms to ED nurses, in addition to their chief complaint. “That needs to be addressed somewhere in the documentation,” Weinstock advises.

ED patients interact with multiple providers — the person at the triage desk, the nurse who checks their vital signs, the person who registers them, the technician who sets them up in a room, and the resident — before they finally see the EP. “They might have told the story six times, and don’t feel the need to repeat it again,” Weinstock says. Many ED patients assume the EP is aware of everything they’ve reported to others.

“We incorporated a triage question into our process: What is the main concern you have today? This helps to focus the evaluation and address the patient’s concerns,” Weinstock says.

Weinstock believes the best approach is for the EP to ask the nurse — or the patient directly, if possible — for clarification. If the nurse documents, “Patient reports headache,” which wasn’t reported to the EP, the EP may learn a moderate headache occurred a week ago and was resolved, or that the headache started 30 min-

utes ago and has increased in intensity. Similarly, if the nurse reports a patient was “lethargic,” more details could show that a serious bacterial infection is unlikely. The EP could then document, “mom explained that the child’s nap was two hours instead of one, and it seemed like it took longer to wake up. The child is now acting normally.”

“The more specific documentation is usually the one that wins out,” Weinstock says.

Defensive Charting

Broocker often sees “blanket defensive charting from nurses, with the infamous ‘MD notified’ after every entry.” Nurses often believe this protects them legally in the event of a malpractice claim. “In one case, we contested this entry. It was a ‘he said/she said.’ Thankfully, it settled,” Broocker recalls.

Broocker says it is always best when the EP and ED nursing docu-

mentation is in sync. “In most of my cases, the EP is an independent contractor. So the nurses are represented separately, and this is not always a given,” he says.

On the other hand, nursing notes such as “patient in no acute distress, resting comfortably, pain resolved” can greatly help the EP’s defense. “These notes are wonderful in cases of discharge or non-emergent disposition,” Broocker says.

In some cases, the EP’s defense is that the patient’s underlying emergency wasn’t evident at the time of the ED visit. “When the nurses back up that the patient objectively looks good in the ED, I always point out these notes as reinforcing our position,” Broocker says.

Broida took this one step further and developed a proactive discharge ambulation policy. Nurses document the patient’s ability to walk a few steps before discharge from the ED. “This ‘road test’ takes almost no time, costs nothing, and acts to confirm the phy-

sician’s neuro assessment in a concrete way,” Broida says.

Such confirmatory charting can be helpful when the patient’s neurologic status evolves over time. “The nurse’s documentation makes the physician’s charting much more credible in court,” Broida says. ■

SOURCES

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Even if They Never Saw a Patient, EPs Still Can Be Named as Defendant

Two decades ago, **Mark Tripp**, MD, FACEP, was named in a malpractice lawsuit for the first time in his career. After he got over the initial shock, he realized that he had never even seen the patient who was suing him.

The patient, a schizophrenic, was being transferred to a state psychiatric facility just as Tripp was arriving for his shift. During his shift, a psychiatrist from the receiving facility called Tripp to ask if the patient could be observed in the ED for a period of time.

“I told him I could not give him advice on a patient I had no knowledge of. My name got written down in the chart,” says Tripp, currently an

EP at Winchester (VA) Emergency Physicians and Front Royal Emergency Physicians. The patient died, and her brother sued as a representative of her estate.

Tripp was shocked to find he had been named in the lawsuit, along with several other clinicians and EPs. He soon found himself preparing for an upcoming deposition, and wanted to obtain compensation from the plaintiff attorney for his time. “I also wanted to sue the lawyer because he wouldn’t drop me from the case,” Tripp says. “I found out I couldn’t do either of those things.” The case was eventually dropped, but only after two years of litigation.

“There was nothing for me to second guess about the care, because I had never even met the person,” Tripp says. “But I had a lot of anger at the system.”

Even if the defense attorney makes it clear that the EP never saw the patient, it’s unlikely the plaintiff attorney will simply dismiss the EP. **Jonathan D. Lawrence**, MD, JD, FACEP, an EP at St. Mary Medical Center in Long Beach, CA, says, “It depends on how reasonable the plaintiff attorney is. But they understand that once a defendant is dismissed, they cannot bring them back into the case.”

John Bedolla, MD, FACEP, medical director of risk management at

U.S. Acute Care Solutions Southwest Region in Austin, TX, notes that states vary in how they define a patient/physician relationship. “But anytime it’s a catastrophic outcome, the plaintiff names as many people as they can,” he says. “It’s about throwing as many deep pockets as they can into the mix.”

Here are some scenarios in which an EP might be named in a lawsuit despite never seeing the patient:

- **If they are supervising a physician’s assistant (PA).**

“If [the] EP is supervising a PA, the EP will be brought into the lawsuit regardless of whether the EP saw the patient or not,” Lawrence says. If an EP is sued for failing to adequately supervise the midlevel practitioner, a typical defense is that the patient presented with a minor complaint, and therefore wouldn’t be seen by the EP.

“The EP says, ‘It is not the sort of patient that I would typically put eyes on,’ I rely on the midlevel and I’m in a supervisory position only,” Lawrence says. The approach may or may not be successful.

Bedolla is aware of a malpractice lawsuit that resulted in a \$20 million verdict against an EP. The case involved a patient who presented with dizziness and was seen by a PA. “The PA performed a pretty bad exam, and didn’t appreciate the gravity of the situation,” he says. “The EP was told about the patient but did not repeat the neurologic exam, so the EP was on the hook.”

Hospitals also can be sued for failing to put protocols in place on which patients the EP is required to see. Although good protocols can be legally protective, good communication can prevent bad outcomes in the first place. “If you encourage a culture of asking questions and cooperation, you won’t get those catastrophic outcomes,” Bedolla says.

EPs might wrongly believe that if

they don’t discuss a patient with the PA, or see the patient, they won’t get sued because their name isn’t on the chart. “The idea that you can’t be sued if you never see the patient is a fallacy,” Bedolla warns.

- **If something is ordered in the EP’s name before a patient is brought back to be seen.**

Tripp explains, “When nurses do triage orders under one of the doctors working, it may or may not be the doctor who actually sees the patient.”

Similarly, if the EP misreads the ECG of a chest pain patient who is still in the waiting room, that EP faces potential liability exposure. “This is because they are taking an action by saying the patient can continue to wait in the waiting room,” Bedolla explains.

If the same chest pain patient experiences a bad outcome while waiting but the EP didn’t read the ECG, Bedolla sees less liability exposure. “Unless there is a positive action by the EP, it’s very hard to successfully sue the EP,” he says. “But if the EP recommended a course of action and there

is a bad outcome related to that, they could be on the hook.”

- **An ED registrar puts the EP’s name on the chart before the patient is seen.**

Since, at that point, registration doesn’t know which EP is going to see the patient, Lawrence says, “the EP can end up getting sued, even though they had nothing to do with the patient.” ■

SOURCES

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CME/CE OBJECTIVES

After completing this activity, participants will be able to:

1. Identify legal issues related to emergency medicine practice;
2. Explain how the legal issues related to emergency medicine practice affect nurses, physicians, legal counsel, management, and patients; and
3. Integrate practical solutions to reduce risk into daily practice.

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CME/CE QUESTIONS

1. Which is true regarding Schumacher Clinical Partners' approach to upfront discussions with patients or attorneys?

- a. By giving EPs the opportunity to explain their medical decision-making, it often becomes apparent to the plaintiff that the standard of care was met.
- b. The group meets with attorneys only if the case is believed to be a strong candidate for settlement, since the process is otherwise not cost effective.
- c. The group has found that the ideal timing of a meeting to discuss pending litigation is after the discovery process is complete.
- d. EPs generally are not included in the meetings because their statements can be used against them in a court of law.

2. Which is true regarding using an ED patient's non-compliance as a defense strategy?

- a. The defense cannot introduce evidence suggesting that the patient contributed to his or her own bad outcome, unless the patient's actions are particularly egregious.
- b. The defense can point out the ED patient's actions, without specifically pleading a contributory negligence defense.
- c. In a comparative fault system, the patient is barred from any recovery if he or she bears some degree of responsibility for the adverse outcome.
- d. The defense can prove contributory negligence simply by demonstrating that the patient failed to care for his or her own safety, regardless of what the patient knew about the risks involved.

3. Which of the following would be covered under every state's existing peer review protections?

- a. Information shared with an ED nurse regarding a topic covered during a peer review meeting, which was relevant to the ED nurse's clinical practice.
- b. Materials produced by an ED group independently, outside the auspices of the hospital or a Patient Safety Organization.
- c. A hospital risk manager's assessment of an adverse outcome in the ED, which was prepared at the request of the peer review committee.
- d. Assessment of ED adverse outcomes conducted by hospital employees outside the peer review process, as long as the goal was to improve patient safety.

4. Which is true regarding EMTALA and malpractice litigation, according to Timothy C. Gutwald, JD?

- a. Attorneys can sue individual EPs for EMTALA violations as part of a malpractice lawsuit, as long as they also can prove negligence occurred.
- b. Fines for EMTALA violations are covered by most medical malpractice insurance policies.
- c. Generally, EPs can successfully countersue plaintiff attorneys who threaten to sue under EMTALA, if the ED chart shows an appropriate medical screening examination was provided.
- d. EMTALA permits the recovery of damages obtainable for personal injury under the forum state's law.