



EMERGENCY MEDICINE LEGAL LETTER™

THE ESSENTIAL RESOURCE FOR EMERGENCY MEDICINE MALPRACTICE PREVENTION AND RISK MANAGEMENT

MAY 2017

Vol. 28, No. 5; p. 49-60

INSIDE

Pitfalls if EP and hospital are joint defendants in med/mal lawsuit 53

How supervising EPs can get off the hook if PA's care is negligent 55

Surprising reason plaintiff attorneys threaten EMTALA claim 57

Legal considerations if law enforcement and EP are at odds 58



live & on-demand WEBINARS

- ✓ Instructor-led Webinars
- ✓ Live & On-Demand
- ✓ New Topics Added Weekly

VISIT US TO LEARN MORE!
AHCMedia.com/Webinars
(800) 688-2421



A RELIAS LEARNING COMPANY

CANDOR: An Evolving Approach to Patient Harm

By David Meyers, MD, FACEP, Sinai Hospital, Baltimore

*"Medicine is inherently dangerous; the dangers cannot be fully controlled, and healthcare is not likely to be completely safe any-time soon."*¹ Richard Boothman, JD, Chief Risk Officer, University of Michigan Health System

In 1999, the publication of *To Err Is Human: Building a Safer Health System*² by the Committee on

Quality in Health Care of the Institute of Medicine (IOM, now the National Academy of Medicine - NAM) brought the country's attention to the magnitude of harm from medical errors, with estimates of up to 98,000 deaths and \$50 billion in costs for adverse events each

year. Nearly half these harmful events were deemed potentially preventable. Also alarming was the declaration that

the disclosure of errors was discouraged by our professional liability system and threat of malpractice, which would

mean "most errors and safety issues go undetected and unreported."²

Two years later, in the follow-up IOM report, *Crossing the Quality Chasm: A New Health System for the 21st Century*,³ the argument was made that "the pursuit of confidentiality is

not a reason for hiding the system's performance from those who depend on the system for care," and a challenge for the future

MEDICAL ERRORS LEAD TO AN ESTIMATED 98,000 DEATHS AND \$50 BILLION IN COSTS EVERY YEAR IN THE UNITED STATES.

NOW AVAILABLE ONLINE! VISIT AHCMedia.com or CALL (800) 688-2421

Financial Disclosure: The following individuals disclose that they have no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study: **Arthur R. Derse**, MD, JD, FACEP (Physician Editor); **Stacey Kusterbeck** (Author); **David Meyers**, MD, FACEP (Author); **Jonathan Springston** (Editor); **Kay Ball**, RN, PhD, CNOR, FAAN, (Nurse Planner); and **Shelly Morrow Mark** (Executive Editor).



ED LEGAL LETTER™

ED Legal Letter™

ISSN 1087-7347, is published monthly by AHC Media, a Relias Learning company
111 Corning Road, Suite 250
Cary, NC 27518
Periodicals Postage Paid at Atlanta, GA 30304 and at additional mailing offices.

POSTMASTER: Send address changes to:

AHC Media, LLC
PO Box 74008694
Chicago, IL 60674-8694

SUBSCRIBER INFORMATION:

Customer Service: (800) 688-2421
Customer.Service@AHCMedia.com
AHCMedia.com

EDITORIAL EMAIL ADDRESS:

jspringston@reliaslearning.com

SUBSCRIPTION PRICES:

Print: 1 year with free AMA PRA Category 1 Credits™: \$519.
Add \$19.99 for shipping & handling.
Online only: 1 year (Single user) with free AMA PRA Category 1 Credits™: \$469

Back issues: \$83. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue's date.
GST Registration Number: R128870672.

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

AHC Media, LLC designates this enduring material for a maximum of 1.5 AMA PRA Category 1 Credits™. Physicians should claim only credit commensurate with the extent of their participation in the activity. Approved by the American College of Emergency Physicians for a maximum of 1.5 hour(s) of ACEP Category I credit.

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

This activity has been approved for 1.5 nursing contact hours using a 60-minute contact hour. Provider approved by the California Board of Registered Nursing, Provider #CEP13791, for 1.5 Contact Hours.

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

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

AUTHOR: Stacey Kusterbeck

EDITOR: Jonathan Springston

EXECUTIVE EDITOR: Shelly Morrow Mark

AHC MEDIA EDITORIAL GROUP MANAGER: Terrey L. Hatcher

SENIOR ACCREDITATIONS OFFICER: Lee Landenberger

Copyright© 2017 by AHC Media, a Relias Learning company. All rights reserved. No part of this newsletter may be reproduced in any form or incorporated into any information-retrieval system without the written permission of the copyright owner.

was announced: “Have no secrets. Make all information flow freely so that anyone involved in the system, including patients and families, can make the most informed choices and know at any time whatever facts may be relevant to a patient’s decision-making.”³ In support of recommendations under Rule 7 of the report, reference was made to published studies that suggested the costs of malpractice might be reduced by disclosure of errors.

It is well known that patients harmed during their care often are subjected to strategies commonly known as “deny and defend,” “wall of silence,” “circling the wagons,” and other such terms reflecting resistance to disclosure of errors and immediate institution of efforts to defend against a possible professional liability action. Injured patients and/or their families are potential adversaries in actions that could affect the physicians’ well-being, finances, and future practice.

Patients, on the other hand, have seen the lack of communication as tacit acknowledgement that the clinician is trying to hide something he or she did wrong, that the clinicians don’t care or respect the patients and don’t want to take responsibility for their actions. The resultant anger leads to the kinds of lawyer commercials seen on television and a desire, not merely for compensation, but for punishment of the “perpetrators.”

Studies have shown that what patients really want in these situations is to know the truth about the event and occurrence, to know it promptly after its occurrence, for clinicians and healthcare organizations to accept responsibility, an apology in recognizing patient harm, an apology from the healthcare practitioner, and an assurance

that other patients will not have similar experiences, i.e., corrective actions will take place. Although monetary reimbursement was not one of the top desires, compensation for injuries and future care needs often came up.⁴

Starting in the late 1980s, health-care institutions in the United States and Canada undertook efforts to look at alternatives to lawsuits and courts for dealing with harms to patients incurred in the process of providing care. The Veterans Administration Hospital in Lexington, KY, was an early pioneer of a model that contained three elements: disclosing the facts surrounding the incident or injury, apologizing and accepting full responsibility, and offering compensation for the harm. Analysis of causes with an intent to address deficiencies also was an important aspect of the program. A similar effort was initiated at the Royal Victoria Hospital in Montreal, Quebec, around the same time.

A widely emulated program based on these ideas was developed and put in place in 2001 at the University of Michigan health system, and the ideas embodied in that program gained traction, inspiring others. The Seven Pillars⁵ approach developed at the University of Illinois and Sorry Works⁶ were established soon thereafter; in addition, many healthcare institutions and even some states have created their own models around these principles.

Since then, such “disclosure, apology, and offer” programs have evolved and become more widely disseminated, especially after The Joint Commission mandated in its accreditation standards for hospitals in 2002 that Sentinel Events and other unanticipated outcomes of care be disclosed to patients and family members, if appropriate.

In addition, the Charter on Physician Professionalism,⁷ published in 2002 with international support, states that physicians have a “commitment to honesty with patients ... Physicians should also acknowledge that in healthcare, medical errors that injure patients do sometimes occur. Whenever patients are injured because of medical care, patients should be informed promptly because failure to do so seriously compromises patient and societal trust.” The American College of Emergency Physicians (ACEP) created a policy on disclosure of errors in 2003,⁸ and the topic has been addressed in other ACEP publications.^{9,10}

In 2012, the Agency for Healthcare Research and Quality (AHRQ) initiated the Communication and Optimal Resolution (CANDOR)¹¹ program, based on some of these earlier models and ideas. Initially aimed at hospitals and health systems, CANDOR has gained interest from physicians and their insurers, including The Doctors Company,¹² Medical Protective,¹³ and others, as well as reinsurers.

The major elements of the CANDOR process are:

1. Promptly communicate with the patient and/or family about the known facts of the adverse event and what might not yet be known with expression of regret/apology.
2. Initiate very early contact after the event with the clinicians involved for fact-finding as well as support in dealing with their feelings related to the event.
3. Stop all billing processes pending investigation and decision-making about how to proceed, including possible offers of compensation.
4. Investigate the factors contributing to the event for purposes of preventing future episodes.

In May 2016, AHRQ published

its comprehensive CANDOR Toolkit to assist healthcare institutions and clinicians with implementation. The toolkit consists of slide sets, lecture materials, and videos in modules to facilitate establishing such a program.

“WHENEVER PATIENTS ARE INJURED BECAUSE OF MEDICAL CARE, PATIENTS SHOULD BE INFORMED PROMPTLY BECAUSE FAILURE TO DO SO SERIOUSLY COMPROMISES PATIENT AND SOCIETAL TRUST.”

Two elements are critical to the success of this effort. One is the full support and active commitment of hospital C-suite leaders, not just administrators — CEO, COO, senior legal counsel, and risk managers, but also clinical leaders, including the chief nursing officer and chief medical officer. Their involvement can be demonstrated by:

- aligning CANDOR processes with the organization’s other strategic priorities;
- helping develop a shared vision among all the players;
- helping the team set goals;
- facilitating progress toward goals;

- removing identified barriers to progress;
- helping define and promote shared accountability for the work of implementing the CANDOR process.

The other element is an organizational culture predicated on principles recognizing that errors will occur, most often not due to negligence or intention, but rather due to human factors such as knowledge deficits, distractions, biases, performance under stress, and so-called system factors such as the work environment, production and time pressures, sudden unexpected occurrences requiring rapid responses, and others.

This “Just Culture”¹⁴ recognizes three types of behavior related to error. Simple human error is an inadvertent mistake, a slip, or lapse — accidentally doing something other than the correct thing. At-risk behaviors are actions that unknowingly increase risk of an adverse event or error, even though they may be possibly justified by circumstances. Reckless behaviors are chosen with knowing disregard for significant and/or unjustifiable risk. A Just Culture avoids “blame, name, shame, and train” approaches to all errors, supports and consoles the clinician who inadvertently errs, and identifies and corrects factors contributing to the error. Those with at-risk behaviors are coached to recognize the potential dangers of these behaviors. Incentives for appropriate behaviors are put in place. There is no tolerance for those who behave recklessly, and remediation and discipline are pursued aggressively with close observation and termination if not improved.

Another important consideration is recognition of and attention to the ongoing needs — financial and

emotional — of the victims of harm and their families. The days, weeks, months, and years following the event are difficult for injured patients and families in many ways, as attested to by the countless comments one sees and hears on the CANDOR videos, on websites, and at meetings of patients and advocacy groups for victims of medical harm. It is essential that patients' interests have primacy, including the offer of legal assistance to help patients in having their interests best served in the disclosure, apology, and offer process.

Where Are We Now?

It is notable that successful disclosure and apology programs have so far been concentrated among hospitals and healthcare systems that employ many of the physicians on their medical staffs and have a greater ability to influence how physicians practice. These physicians often are insured through corporate entities, allowing for coordination of approaches among the parties and the availability of greater resources devoted to resolving these cases.

Adoption among individual and group physician practices has been growing under the influence of insurers promoting their use and providing training for clinicians, but significant concerns remain, impeding widespread acceptance.

Notwithstanding the interest, there is ongoing debate over the actual effects of these programs. Although several studies have been published demonstrating greater transparency, significantly fewer malpractice claims, and lower related costs,¹⁵ a recent Vanderbilt study¹⁶ disputed this result. The reasons are not clear, and the study itself has been criticized for its assumptions and conclusions.

Other studies are in progress.

The skills used in disclosure and apology are not natural to many; therefore, training is required so that the situation is not made worse. Furthermore, nothing in the disclosure and apology programs prevents patients who have been injured from filing claims in the legal system, and, although the trend is away from this,

THE UNIQUE CHARACTER OF EMERGENCY MEDICINE PRESENTS NUMEROUS CHALLENGES TO THE IMPLEMENTATION AND EFFECTIVENESS OF DISCLOSURE AND APOLOGY EFFORTS.

the disclosures and apology themselves still may be used as evidence against the physician in some states.

At least 39 states have enacted laws addressing alternative resolution, including one or more elements of disclosure and apology. A 2010 study¹⁷ reviewed the landscape of statutes across the country and found wide variation in definitions, protected and required actions, and how they should be carried out. The authors recommended some best practices they believed would make the statutes more effective and the programs more acceptable to physicians.

The unique character of emergency medicine presents numerous challenges to the implementation and effectiveness of disclosure and apology efforts. The unpredictable nature of the work environment; often high volumes and patient acuity; production pressures; episodic care with no long-term patient relationships; limited historical information about patients; frequent transitions of care between and among physicians, nurses, and others; lack of accurate contact information for patients; difficulty monitoring outcomes for patients who have left the ED either via discharge or admission to in-patient beds — all these factors can increase the risk of errors and reduce opportunities to recognize and disclose them at all, let alone in a timely way.¹⁸

Finally, CANDOR and similar approaches do not alleviate the concerns of physicians about reporting to state regulatory and licensing bodies nor the National Practitioner Data Bank (NPDB), since now there is no standard waiver from those reporting requirements.¹⁹ Reporting to the NPDB can be avoided by several means consistent with the law, but fear of reporting is still a strong incentive to avoid open communication, disclosure, and apology. Robert Blasio, CEO of Western Litigation, Inc., which handles hundreds of emergency medicine claims for many of the largest emergency medicine physician practice management companies as well as hospitals and healthcare institutions, has seen movement toward disclosure and apology, but so far, institutional use far outpaces its adoption in the physician sector, and that is likely to continue.

Although CANDOR and other programs of disclosure, apology, and offer provide some relief to

the victims of healthcare-induced harm, and are gaining in acceptance, their actual effect on claims, costs, and satisfaction is yet to be fully determined.

While most agree transparency, forthrightness, and “doing the right thing” for patients and their families are ethical imperatives, practical concerns and lack of definitive data have yet to prove conclusively they will make a difference. ■

REFERENCES

1. Boothman RC. CANDOR: The antidote to deny and defend? *Health Serv Res* 2016;51 Suppl 3:2487-2490.
2. Institute of Medicine, Committee on Quality of Health Care in America. *To Err Is Human: Building a Safer Health System*. National Academies Press; 2000.
3. Institute of Medicine, Committee on Quality of Health Care in America. *Crossing the Quality Chasm: A New Health System for the 21st Century*. National Academies Press; 2001.
4. Vincent C, Young M, Phillips A. Why do people sue doctors? A study of patients and relatives taking legal action. *Lancet* 1994;343:1609-1613.
5. McDonald TB, Helmchen LA, Smith KM, et al. Responding to patient safety incidents: The “seven pillars.” *Qual Saf Health Care* 2010;19:e11.
6. Sorry Works! Available at: <http://bit.ly/1WUJEqy>. Accessed March 1, 2017.
7. ABIM Foundation. Medical professionalism in the new millennium: A physician charter. *Ann Intern Med* 2002;136:243-246.
8. American College of Emergency Physicians. Disclosure of medical errors. Available at: <http://bit.ly/2meB9f7>. Accessed March 1, 2017.
9. Marco AC. How to handle a medical mistake. *ACEP Now*, April 13, 2016. Available at: <http://bit.ly/2mLqq8n>. Accessed March 1, 2017.
10. Moskop J. Patients and medical errors — to tell the truth? *ACEP News*, August 2007. Available at: <http://bit.ly/2mtYpX2>. Accessed March 1, 2017.
11. Agency for Healthcare Research and Quality. Communication and Optimal Resolution (CANDOR) Toolkit. Available at: <http://bit.ly/2m9fch7>. Accessed March 1, 2017.
12. The Doctors Company. CANDOR Toolkit: Physicians now have the right tools to do the right thing after an adverse event. Available at: <http://bit.ly/2lX88C7>. Accessed March 1, 2017.
13. MedPro Group. Disclosure: When an unanticipated event occurs. November 2012. Available at: <http://bit.ly/2ld4OWo>. Accessed March 1, 2017.
14. Outcome Engenuity. What does our model of accountability look like? Available at: <http://bit.ly/2mFJSV6>. Accessed March 1, 2017.
15. Boothman RC, Blackwell AC, Campbell DA Jr, et al. A better approach to medical malpractice claims? The University of Michigan experience. *J Health Life Sci Law* 2009;2:125-159.
16. McMichael BJ, Van Horn RL, Viscusi WK. Sorry is never enough: The effect of state apology laws on medical malpractice liability risk, Dec. 10, 2016. Available at: <http://bit.ly/2lrSBbk>. Accessed March 1, 2017.
17. Mastroianni AC, Mello MM, Sommer S, et al. The flaws in state ‘apology’ and ‘disclosure’ laws dilute their intended impact on malpractice suits. *Health Aff* 2010 29:1611-1619.
18. Moskop JC, Geiderman JM, Hobbgood CD, Larkin GL. Emergency physicians and disclosure of medical errors. *Ann Emerg Med* 2006;48:523-531.
19. Mooreim H. Candor about adverse events: Physicians versus the data bank. *Hastings Cent Rep* 2015;45:9-10.

Are EP and Hospital Jointly Defending Med/Mal Lawsuit?

EP will face repercussions if pointing finger at hospital

An ED nurse receives an appropriate medication order from an EP, but administers the wrong dosage, harming the patient. If the ED nurse and EP are both named in the resulting malpractice lawsuit, “the interests of the hospital and the physician will not be aligned,” says **Susan Martin, Esq.**,

executive vice president of litigation management and loss control in the Plano, TX, office of AMS Management Group.

The EP must testify as to why the medication order was reasonable and safe, and that the ED nurse gave an incorrect dose. “The EP likely respects the nurses in the ED, and

does not want to be critical,” Martin explains. However, as a defendant in a malpractice lawsuit, EPs must look out for their own interests. This means defending the medication order and preparing for difficult questions at deposition. “Even in these days of hospitals employing physician groups, clearly the physi-

cian should have his own counsel to represent him,” Martin advises.

Both the nurse’s attorney and the physician’s attorney can work together to defend the lawsuit. “But the EP should not have to be concerned that any settlement will be against him or the ED group in a case of clear liability against an ED nurse,” Martin adds.

David L. Rogers, JD, founding shareholder of Michigan-based Rogers & Associates, has seen the interests of hospitals and EPs conflict in litigation several times. At the beginning of a case, the EP is aware there was a bad event and the patient was harmed — but often doesn’t know initially how it happened.

“Without vigilance on behalf of the EP, it’s possible that no one will figure out what really happened — or that whoever figures it out won’t tell the EP,” Rogers says.

Sometimes, the source of the fault isn’t apparent until considerable discovery — depositions, document production, and expert analysis — is complete. “If there is any possibility that the EP is not at fault but the hospital is, the EP should immediately request a separate attorney,” Rogers advises.

Liable for EP’s Actions?

Most state laws require hospitals

to provide appropriate facilities and a full range of emergency and ancillary care, “but many attempt to insulate themselves from liability,” says **Kenneth T. Lumb**, JD, an attorney with Corboy & Demetrio in Chicago. For instance, hospitals protect themselves legally by contracting with individuals or corporate entities to provide EPs.

However, in most states, the hospital still can be held liable for the negligence of independent contractors through the doctrine of apparent agency. This applies when a hospital holds itself out as providing a full range of services, with patients relying on the hospital to provide them — without realizing the EP caring for them is an independent contractor.

“Even when apparent agency doesn’t apply, however, the hospital is often left without a chair when the music stops,” Lumb notes. “There is almost always an inherent conflict between an EP’s interests and a hospital’s.”

A plaintiff attorney always can plausibly allege that an EP’s medical error was caused or enabled by a system deficiency, for instance, such as a lack of appropriate policies.

The only foolproof solution to avoid these conflicts is for a hospital to hire its EPs, Lumb says. “These facilities never have to worry about the ethical or practical issues of conflict-

ing interests, and can always present a unified defense.”

Separate Attorney for EP

Are an EP and hospital blaming each other for a patient’s bad outcome? The governing state ethical provisions likely prohibit an attorney from representing both parties, says **David S. Waxman**, JD, an attorney in the Chicago office of Arnstein & Lehr.

He gives this example: An EP claims no one told her about a critical lab value, but an ED nurse testifies otherwise. “Those theories are entirely in conflict,” Waxman says. “Unless that conflict has somehow been explicitly and effectively waived, then one of those defenses should be spun off to a different lawyer.” Faced with this scenario, he recommends EPs request appointment of separate counsel.

Often, the EP is an independent contractor of the hospital with independent counsel, and the EP’s defense conflicts with the narrative of a hospital employee. For example, an employed hospitalist claims a diagnosis was delayed because the EP failed to communicate pertinent history, but the EP disputes this account.

“The options here are rather limited,” Waxman says. If the EP points a finger at the hospital, it could undermine the business relationship between the EP’s employer and the hospital with which it contracts.

“It is certainly not uncommon in litigation for punches to be pulled because the underlying business relationship is much more important than the potential damage resulting from a particular lawsuit,” Waxman says.

EXECUTIVE SUMMARY

The EP’s and hospital’s interests as joint defendants in malpractice litigation sometimes conflict, necessitating separate counsel for the EP.

- Sometimes, the source of the fault isn’t apparent until discovery has been completed.
- In most states, hospitals can be held liable for the negligence of independent contractors through the doctrine of apparent agency.
- Attorneys are prohibited ethically from representing both the hospital and EP if their positions conflict.

Some EP defendants try to find common ground with the hospital. For instance, the EP can soften testimony regarding conversations that would prove a hospital employee was at fault. However, the tradeoff for diminishing the EP's otherwise effective defense might be a National Practitioner Data Bank (NPDB) report. "Many EPs would find that unacceptable, and prefer to fight it out with the hospital," Waxman notes.

The effect of an NPDB report and the EP's business relationships are two important factors for defense attorneys to consider. "This allows the EP to make well-informed strategic decisions," Waxman explains.

Problems can arise if the EP believes the malpractice event was the fault of a hospital employee or faulty hospital equipment, but the hospital disagrees. Rogers adds, "Sometimes, the hospital's position on this can depend on the physician's status in the hospital — favored or not favored, liked or disliked."

If the hospital provides the EP's coverage, the usual practice is for the insurer to provide one defense attorney for both parties. Rogers says, "The physician is often far better off if the insurance provides a separate attorney for him or her. But that's an expensive proposition for the

insurance company — or hospital, if self-insured — and not always necessary." Here are some important considerations:

- **If an attorney representing both the hospital and EP believes that their positions conflict, the attorney is prohibited ethically from representing both.**

"Depending on the conflict, the attorney may be prohibited from representing either of them if the case has progressed substantially before the conflict is discovered or recognized," Rogers says.

- **If the hospital and EP retain separate attorneys from the beginning, the EP should consider carefully whether to assert claims that the hospital is at fault.**

"If it's true and provable, the EP's attorney will probably want to discuss the matter with the hospital's attorney," Rogers says. "Hospitals are often amenable to protecting their physicians from unfounded allegations."

- **Damage from a serious malpractice lawsuit usually is much worse for an EP's career than for a hospital's operations.**

"In general, I think the EP should assert a well-founded, supportable position against the hospital, to protect himself or herself," Rogers adds.

ED groups might not want to

engage in a conflict with a hospital. But for the individual EP who is a defendant in the case, receiving an adverse medical malpractice case settlement or judgment could be devastating.

"It's easier to get another job than another career," Rogers says. If the individual EP did not commit malpractice but there was fault on the part of the hospital, he continues, "the individual EP should not roll over for the benefit of the group's relationship with the hospital, which amounts to taking one for the team." ■

SOURCES

- **Kenneth T. Lumb**, JD, Corboy & Demetrio, Chicago. Phone: (312) 346-3191. Email: ktl@corboydemetrio.com.
- **Susan Martin**, Esq., Executive Vice President, Litigation Management/Loss Control, AMS Management Group, Fort Lauderdale, FL. Phone: (866) 520-6896. Fax: (817) 704-4291. Email: smartin@amsmanagementgroup.com.
- **David L. Rogers**, JD, Rogers & Associates, Farmington Hills, MI. Phone: (248) 702-6350 (Ext. 104). Fax: (248) 246-2280. Email: drogers@healthlex.com.
- **David S. Waxman**, JD, Arnstein & Lehr, Chicago. Phone: (312) 876-7867. Email: DSWaxman@arnstein.com.

What Happens When an ED Chart Shows PA 'Went Rogue?'

EP can be held liable if physician assistant's care was negligent

In medical malpractice cases involving allegations of negligent treatment or misdiagnosis by a physician assistant (PA), supervising EPs typically find themselves named as

defendants. This usually is the case, even if the PA is the only one whose care is called into question.

The supervising EP ultimately was dismissed from one recent case,

but only after a prolonged discovery period. The PA had consulted with the EP without revealing all relevant components of the history and physical exam.

“The PA obtained the EP’s signature based upon these edited facts, and essentially decided to ‘go rogue’ in the medical decision-making process,” says **Nan Gallagher**, JD, who defended the EP. Gallagher is director of the healthcare practice at Beinhaker, Gallagher & Goodgold in Millburn, NJ. The patient died because of receiving treatment for the wrong condition. The EP was dismissed from the claim for these reasons:

- The EP was fully compliant with the governing mandates;
- There was very complete documentation that the EP had been partially informed by the PA when deciding treatment and ordering prescriptions. Based on this evidence, Gallagher says, “the EP in no way could arguably have been found to have deviated from accepted standards of care.”

In contrast, a judge refused to dismiss another EP from a claim involving care provided by a PA. The plaintiff demonstrated the EP had very limited involvement in the oversight of the PA. The supervising EP was not required to be present during the patient’s exam in the ED or to co-sign anything contained in the chart.

“The PA made independent decisions to prescribe the wrong medication and dosage, which led to the patient’s demise,” Gallagher notes.

The court found the EP’s oversight was insufficient, leaving the

claims against the EP in the hands of the jury. “The physician was hit with a \$500,000 verdict against him, which will have a rippling effect on his career from an administrative and credentialing standpoint hereafter,” Gallagher says. To be dismissed from a malpractice case, Gallagher notes the EP’s defense attorney must show:

- that appropriate judgment was exercised at all times under the facts presented;
- that supervision and co-signature are “hands-on” responsibilities.

Contemporaneous entries by the EP and PA in the progress notes are important supporting pieces of documentation. “I also advise all of my EP clients to insist that the PA document the EP’s involvement and interaction as much as accurately possible in the chart,” Gallagher adds.

Additionally, it’s vital that the EP was not negligent in any way toward the patient. If the plaintiff attorney paints the EP as failing to take the supervisory role seriously, this damages the defense. “EPs must be cognizant of the fact that their training and level of expertise outranks that of any PA,” Gallagher stresses.

Not Second-class Care

Sean P. Byrne, JD, a medical malpractice defense attorney in the Glen Allen, VA, office of Hancock, Daniel, Johnson & Nagle, likes to see the ED

chart indicate expressly whether the PA consulted with the supervising EP. “The question ‘Did you consult with the EP or not?’ often gets raised,” he says.

The EP’s signature doesn’t mean he or she offered any input into the patient care. In some cases, the EP wasn’t even aware the patient was in the ED. Many times, says Byrne, “the EP gets sued just because they are on the chart, and can’t remember the case.” It eventually becomes clear the EP did not direct the clinical care in any way. “Over time, the facts play out, and it becomes clear there is no basis for liability,” Byrne adds.

While time-stamping shows the chart was read and reviewed by the EP, sometimes that is not placed into the record until well after the patient has been discharged. “It is helpful if the chart specifically notes when the EP is directly consulted and weighs in on patient care, as opposed to simply signing off on the chart as a matter of routine,” Byrne advises.

When a PA was sued for failing to diagnose a subarachnoid hemorrhage, the supervising EP wasn’t named in the lawsuit. “The PA saw the patient, ordered the testing, and wrote the differential,” Byrne says. All the EP did was sign off on the chart hours later.

“When the role of the EP is merely to supervise and remain available to consult with the PA, but they do not actively participate in the care, they are one step removed and may not be included as a defendant,” Byrne explains.

Plaintiffs often include a “failure to supervise” claim in the initial stages of a lawsuit, when the facts surrounding the EP’s involvement — or lack thereof — are unclear.

“The plaintiff will paint a picture of a factory — not patient-focused, individual care,” Byrne warns. “We

EXECUTIVE SUMMARY

Supervising EPs typically are named in malpractice lawsuits alleging negligent care by a physician assistant. This documentation makes it more likely the EP will be dismissed:

- The EP used appropriate judgment.
- The EP took the supervisory role seriously.
- The EP was not negligent in any way toward the patient.

have to demonstrate that the patient got good care.” The defense must demonstrate the patient wasn’t receiving second-class care just because he or she saw a PA.

“It is important in these cases to prove that the patient presentation was such that it was well within the scope of practice for the PA to treat the condition,” Byrne says. Likewise, proving that the PA is a well-creden-

tial, competent, skilled clinician helps reassure the jury that the care was appropriate. Detailed documentation is vital.

“When the chart contains not just drop-down menu clicks, but patient-specific observations, the differential diagnosis, and treatment/disposition plans, the jury will be more inclined to view the care favorably,” Byrne says. ■

SOURCES

- **Sean P. Byrne**, JD, Hancock, Daniel, Johnson & Nagle, Glen Allen, VA. Phone: (804) 237.7409. Email: sbyrne@hdjn.com.
- **Nan Gallagher**, JD, Director, Healthcare, Beinhaker, Gallagher & Goodgold, Millburn, NJ. Phone: (908) 364-5655. Fax: (908) 233-4546. Email: nan@beinlaw.com.

EMTALA Claim Against Individual EP: ‘Almost Always an Empty Threat’

Some use EMTALA as leverage to coerce settlement

Plaintiffs are not entitled legally to win on a claim against any individual EP under the Emergency Medical Treatment and Labor Act (EMTALA). Surprisingly, this doesn’t stop some attorneys from threatening to file these claims.

“Most of the time I’ve seen it, it’s been either a mistake or an attempt to obtain leverage in an attempt to coerce the defense into settling,” says **Andy Walker**, MD, FAAEM, a Signal Mountain, TN-based EP who offers legal consultation on the defense of EPs.

No Cause of Action

Federal courts have ruled consistently that EMTALA is not a malpractice statute. “Negligence has nothing to do with EMTALA,” Walker explains. “Unless the ED is treating people differently based on their financial resources and insurance, EMTALA has nothing to do with it.”

Some plaintiff attorneys file an EMTALA suit anyway, just to intimidate the defense. “You need a defense

attorney who understands that filing an EMTALA claim is usually groundless and that it’s just a legal maneuver, and responds appropriately,” Walker says. “It’s almost always an empty threat.”

Even if EMTALA was violated, there is no cause of action for a civil suit against the EP. “A lot of EPs don’t realize that,” Walker notes. “All they realize is that they can be fined up to \$50,000 for a single EMTALA violation, which isn’t covered by their malpractice insurance.”

There are two common allegations: that the patient should have

been admitted, but was improperly discharged from the ED, or that the patient was subjected to an inadequate medical screening exam. “I’ve even seen cases where the patient was admitted to the hospital, something bad happens after discharge, and the plaintiff attorney alleges an EMTALA violation — even though the patient was admitted to the hospital,” Walker recalls.

Some plaintiff attorneys who add an EP to an EMTALA lawsuit are confusing an inadequate screening exam with negligence. If an EP sends a chest pain patient home who later

EXECUTIVE SUMMARY

Plaintiff attorneys cannot recover against individual EPs under EMTALA, but some still threaten to in an attempt to coerce the defense to settle the claim. Some considerations:

- Fines are not covered by medical malpractice insurance, but defense costs may be.
- EMTALA claims directed against individual EPs generally can be dismissed quickly and easily.
- EMTALA claims are easier and less costly for plaintiff attorneys than negligence claims.

dies of a heart attack, Walker says, “it may or may not be negligent — but it’s certainly not an EMTALA violation.”

Quick, Easy Dismissal

William M. McDonnell, MD, JD, medical director of the ED at Children’s Hospital & Medical Center in Omaha, NE, says EMTALA claims directed against individual EPs generally are dismissed quickly and easily.

However, says McDonnell, “plaintiff’s attorneys often will add a claim against the hospital under EMTALA to their malpractice claim, or even preferentially seek to characterize their malpractice claim as an EMTALA claim.” The amount of the personal injury award likely will not be greater under EMTALA than under negligence principles. However, there are certain advantages for the plaintiff.

“EMTALA claims are easier — and less expensive — for plaintiff attorneys to bring,” McDonnell says. EMTALA claims generally avoid the pre-trial barriers that many states have enacted for malpractice claims, such as pre-litigation review panels.

“Additionally, EMTALA claims are easier for plaintiffs to win,” McDonnell adds. In malpractice cases, the plaintiff must prove that the defendant EP acted “unreasonably,” and that a reasonable EP under the same or similar circumstances would not have acted, or failed to act, in the same manner as the defendant. “This generally necessitates expensive expert witnesses testifying for the plaintiff,” McDonnell says.

Under EMTALA, the burden of proof is much easier for the plaintiff to meet. “EMTALA is essentially a strict liability statute,” McDonnell explains. “The plaintiff simply needs to prove the underlying facts.”

The plaintiff would need to show only that the patient came to the hospital, that a request was made for care, and that a medical screening exam was not provided. It is unnecessary for the plaintiff to compare the defendant’s actions to a “reasonableness” standard.

“There is generally no need for the plaintiff to find an expert witness to testify about what a reasonable provider would have done,” McDonnell adds. ■

SOURCES

- **William M. McDonnell, MD, JD**, Medical Director, Emergency Department, Children’s Hospital & Medical Center, Omaha, NE. Phone: (402) 955-5142. Email: wmcdonnell@ChildrensOmaha.org.
- **Andy Walker, MD, FAAEM**, Signal Mountain, TN. Email: awalkermd@comcast.net.

EPs Caught Between Patient Care and Law Enforcement Requests

EP s interact with law enforcement on a regular basis, with police-escorted prisoners, patients suspected of driving while intoxicated, and victims and perpetrators of assault. Such interactions pose some unique legal risks for EPs.

“Conflicts may arise in a variety of circumstances,” says **Catherine A. Marco, MD, FACEP**, professor in the department of emergency medicine at Wright State University in Dayton, OH.

If a suspected or convicted criminal arrives in the ED, law enforcement officers are anxious to obtain evidence, interview the patient, or expedite the patient’s discharge. EPs have a different priority — the

duty to assess and treat the patient’s medical condition, regardless of the patient’s status with the law.

“EPs should work collaboratively with law enforcement to ensure prioritization of medical treatment,” says Marco, who co-authored a recent paper on this topic.¹

Sometimes, there is disagreement between EPs and law enforcement as to the use of force to detain patients. “Law enforcement may wish to detain a patient and enforce medical care, but the physician may judge that the patient has capacity to refuse care,” Marco says.

Similarly, there can be differences of opinion regarding the prioritization of interviews, evidence

collection, and medical treatment. The bottom line: EPs always must consider the patient’s best interest. “Medical treatment should always take priority over evidence or information collection,” Marco says, adding that the best approach is to perform procedures and diagnostic tests that are clinically indicated.

Local police, in an attempt to carry out their duty to investigate and prosecute criminal activity, may enter the ED to search and question patients. **William M. Mandell, JD**, an attorney at Pierce & Mandell in Boston, says, “The ED needs to always be mindful that while it wants to cooperate with law enforcement, it has other legal and ethical duties

to uphold patients' rights."

These include the patient's right to privacy. "This is a constant balancing act that needs to be looked at," Mandell stresses. "If you don't get this right, it can be a cause of liability."

'In the Middle' of DUIs

Some EPs have been sued for acting as the extension of law enforcement in illegal searches and seizures. "This can occur if an ED clinician obtains a blood alcohol level in a patient suspected of a DUI," Mandell says.

EPs can find themselves "in the middle" of DUI cases, he explains. This happens when alleged DUI perpetrators are brought to the ED after motor vehicle accidents. Massachusetts, like many other states, has an "implied consent law" that applies to drivers who are stopped for suspected DUI. The law provides that all drivers give their implied consent to undergo a blood or breath test if they are lawfully arrested on suspicion of drunk driving.

"But unless the police officer has a warrant to take the driver's blood, they cannot force the driver to provide a sample of his or her blood," Mandell explains. However, they can ask a driver to submit to a blood sample, if the driver is an ED patient under arrest for DUI.

"Patients obviously have privacy and Fourth Amendment constitutional rights, as discussed in the most recent Supreme Court case on the matter," Mandell says.²

HIPAA and most state laws allow for unauthorized minimally necessary disclosures to address ongoing major criminal actions. As for how this applies to an ED patient, Mandell says: "One way to think about

it is: Is there an ongoing public emergency or criminal action? Or is it an investigation of a prior alleged action?"

Generally, non-consensual blood samples should be taken at the direction of the police for a patient in custody under arrest with a search warrant. "EDs should weigh this carefully, with the advice of good local counsel who understands the applicability of local and state laws," Mandell advises. ■

REFERENCES

1. Baker EF, Moskop JC, Geider-

man JM, et al. Law enforcement and emergency medicine: An ethical analysis. *Ann Emerg Med* 2016;68:599-607.

2. *Missouri v. McNeely* 569 U.S. (2013).

SOURCES

- **William M. Mandell**, JD, Pierce & Mandell, Boston. Phone: (617) 720-2444. Fax: (617) 619-7231. Email: bill@piercemandell.com.
- **Catherine A. Marco**, MD, FACEP, Professor, Department of Emergency Medicine, Wright State University, Dayton, OH. Phone: (937) 395-8839. Email: catherine.marco@wright.edu.

CME/CE INSTRUCTIONS

To earn credit for this activity, please follow these instructions:

1. Read and study the activity, using the provided references for further research.
2. Log on to **AHCMedia.com** and click on **My Account**. First-time users must register on the site using the eight-digit subscriber number printed on their mailing label, invoice, or renewal notice.
3. Pass the online tests with a score of 100%; you will be allowed to answer the questions as many times as needed to achieve a score of 100%.
4. After successfully completing the test, a credit letter will be emailed to you instantly.
5. Twice yearly after the test, your browser will be directed to an activity evaluation form, which must be completed to receive your credit letter.

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.

COMING IN FUTURE MONTHS

- How e-discovery is changing ED malpractice litigation
- Disprove allegations that no one followed up on test ordered in ED
- Must-have ED documentation to defend delayed diagnosis claims
- How plaintiff attorneys use EMR time-stamping to prove negligence



ED LEGAL LETTER™

PHYSICIAN EDITOR

Arthur R. Dershe, MD, JD, FACEP
Director and Professor, Center for Bioethics and Medical Humanities, Institute for Health and Society, Medical College of Wisconsin, Milwaukee

NURSE PLANNER

Kay Ball, PhD, RN, CNOR, FAAN
Associate Professor, Nursing, Otterbein University, Westerville, OH

EDITORIAL ADVISORY BOARD

Sue A. Behrens, RN, DPN, ACNS-BC, NEA-BC
Senior Director, Ambulatory and Emergency Department, Cleveland Clinic Abu Dhabi, Abu Dhabi, United Arab Emirates

Robert A. Bitterman, MD, JD, FACEP
President, Bitterman Health Law Consulting Group, Inc., Harbor Springs, MI

Kevin Klauer, DO
Chief Medical Officer, TeamHealth, Knoxville, TN

Jonathan D. Lawrence, MD, JD, FACEP
Emergency Physician, St. Mary Medical Center, Long Beach, CA

William M. McDonnell, MD, JD
Clinical Service Chief, Pediatric Emergency Medicine Medical Director, Emergency Department Children's Hospital & Medical Center, Omaha, NE

Larry B. Mellick, MD, MS, FAAP, FACEP
Professor of Emergency Medicine, Professor of Pediatrics, Department of Emergency Medicine, Augusta University, Augusta, GA

Gregory P. Moore, MD, JD
Attending Physician, Emergency Medicine Residency, Madigan Army Medical Center, Tacoma, WA

Richard J. Pawl, MD, JD, FACEP
Associate Professor of Emergency Medicine, Augusta University, Augusta, GA

William Sullivan, DO, JD, FACEP, FCLM
Director of Emergency Services, St. Margaret's Hospital, Spring Valley, IL; Clinical Instructor, Department of Emergency Medicine, Midwestern University, Downers Grove, IL; Clinical Assistant Professor, Department of Emergency Medicine, University of Illinois, Chicago; Sullivan Law Office, Frankfort, IL

Interested in reprints or posting an article to your company's site? There are numerous opportunities for you to leverage editorial recognition for the benefit of your brand. Call us at (800) 688-2421 or email us at Reprints@AHCMedia.com.

Discounts are available for group subscriptions, multiple copies, site-licenses, or electronic distribution. For pricing information, please contact our Group Account Managers at Groups@AHCMedia.com or (866) 213-0844.

To reproduce any part of AHC newsletters for educational purposes, please contact The Copyright Clearance Center for permission:

Email: info@copyright.com
Website: www.copyright.com
Phone: (978) 750-8400

CME/CE QUESTIONS

1. Which of the following statements is true if the EP and hospital are joint defendants in malpractice litigation, according to David L. Rogers, JD?

- Depending on the conflict, the attorney may be prohibited from representing either the EP or the hospital if the case has progressed substantially before the conflict is discovered.
- It is too late for an EP to request a separate attorney if it becomes apparent only after extensive discovery that a hospital employee, not the EP, was at fault for a bad outcome.
- Generally, it is acceptable for attorneys to continue representing both the hospital and EP, even if their positions conflict in some ways, as long as the conflict is disclosed.
- Requesting a separate attorney puts the EP at a clear disadvantage if there is a possibility that the hospital is at fault.

2. Which of the following statements is true regarding hospital liability for the negligence of EPs, according to Kenneth T. Lumb, JD?

- For the doctrine of apparent agency to apply, patients must be aware that the EP is not a hospital employee.
- In most states, the hospital can be held liable for the negligence of independent contractors through the doctrine of apparent agency.
- Conflicting interests occur more often if EPs are hospital employees.
- Hiring EPs as employees

instead of using independent contractors ensures that the hospital cannot be held liable for the EPs' negligence.

3. Which of the following is recommended to reduce liability risks involving EPs supervising PAs, according to Sean P. Byrne, JD?

- Co-signing the ED chart with no direct involvement in patient care as a matter of routine
- Encouraging PAs to consult supervising EPs only if patients request to see an EP
- Implementing hospital policies that specifically state the supervising EP does not need to have direct involvement in patient care
- Directing PAs to clearly document whether the EP was directly consulted on patient care

4. Which of the following statements is true regarding EMTALA claims?

- EMTALA fines are covered by most medical malpractice insurance policies.
- Once an EMTALA claim is directed against an individual EP, it's unlikely to be dismissed without a thorough investigation.
- Plaintiff attorneys cannot recover against individual EPs under EMTALA.
- EMTALA claims require a higher burden of proof than negligence claims.