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INSIDE

EMTALA Protects Health Professionals Who Report Potential Violations

By Joseph P. McMenamin, Principal, McMenamin Law Offices, PLLC

Assume the following facts: During her tenure, a physician's assistant (PA) employed by the hospital to staff its ED alleged numerous violations of the Emergency Medical Treatment and Active Labor Act (EMTALA), such as physician failures to see patients in a timely fashion or refusals to transfer cases appropriately. About 18 months after she accepted employment, the hospital advised the PA, contrary to its prior representations, that she and all other ED PAs would be replaced by physicians.

The PA's husband, an emergency physician (EP) employed by the same hospital, had likewise alleged violations of EMTALA. He, too, was terminated. The doctor claimed he had seen inappropriate transfers, physician failures to evaluate or admit patients timely, failures to stabilize, and failures to supply the hospital's on-call list to area ambulance services. About one year after his employment and one day after reappointing him to the staff, and in contravention of its bylaws, the hospital issued a reprimand. A few months later, the hospital terminated the physician's employment contract without cause, and later, without due process, removed him from the active medical staff roster. The hospital also frustrated the doctor's efforts to pursue opportunities for employment elsewhere by refusing to disclose its knowledge of his capabilities. Finally, in retaliation for his reports of safety concerns and EMTALA violations, the hospital completed a professional review process, revoked the physician's staff privileges, and published a report of its adverse action to both the National Practitioner's Data Bank and to the Maine Board of Licensure in Medicine.

The husband and wife sued the hospital, alleging improper retalia-

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tion under EMTALA. The hospital moved for summary judgment, asserting that trial was unnecessary because the undisputed facts and the law made it clear the plaintiffs could not prevail.

What should the court do?

The Statute

Congress passed EMTALA to discourage patient dumping, the practice of transferring indigent or uninsured patients from private to public hospitals. Briefly stated, EMTALA imposes two duties upon hospitals participating in the Medicare program: 1) to provide "an appropriate medical screening examination,"[1] and 2) to "stabilize" any emergency medical conditions detected by the medical staff before transferring or discharging the patient.[2]

CONGRESS PASSED EMTALA TO DISCOURAGE PATIENT DUMPING, THE PRACTICE OF TRANSFERRING INDIGNENT OR UNINSURED PATIENTS FROM PRIVATE TO PUBLIC HOSPITALS.

The Whistleblower Protections

Congress sought to encourage healthcare professionals to report EMTALA violations by providing whistleblower protections: "A participating hospital may not penalize or take adverse action against a qualified medical person [QMP] … or a physician because the person or physician refuses to authorize the transfer of an individual with an emergency medical condition that has not been stabilized or against any hospital employee because the employee reports a violation of a requirement of this section."

The QMP need not be a physician. The QMP may be a nurse or another provider "designated … in a document that is approved by the governing body of the hospital. Those health practitioners designated to perform medical screening examinations are to be identified in the hospital bylaws or in the rules and regulations governing the medical staff following governing body approval."[3]

EMTALA's text seems, then, to set up two forms of protection: 1) for QMPs and doctors refusing to authorize transfers that EMTALA makes unlawful and 2) for any hospital employee who reports any EMTLA violation. So far, only a relatively modest number of lawsuits have interpreted the whistleblower protection clause, but they do provide some helpful guidance to the student of EMTALA. Moreover, as it does in other contexts, the law analogizes from similar situations to interpret the legislative text.

In EMTALA retaliation claims specifically, the law sometimes looks to precedent from retaliation cases under the Civil Rights Act of 1964. Borrowing from those authorities,

courts have concluded that to establish a prima facie claim of EMTALA retaliation, a plaintiff must prove that:

1. he engaged in activity protected by EMTALA;

2. he suffered an adverse employment action at the hands of his employer; and

3. a causal connection exists between the protected activity and the employer's decision to impose the adverse employment action.[4]

Applying the Protections

The fact pattern sketched out above is taken from a real case, still pending, probably headed for trial next summer. The defendant hospital moved for summary judgment, claiming that there was no need for trial because, even if all facts pleaded were true, there was no basis for the court to find for the plaintiffs. Its motion was denied.[5] This decision does not mean that the hospital's actions were wrong, or that the plaintiffs will win. However, it does mean, according to the court, that if the facts turn out to be as the plaintiffs claim, they have stated a claim worthy of consideration on the merits, not to be short-circuited by summary judgment. In short, the EP husband and the PA wife will get their day in court.

A federal court in Massachusetts reached a similar conclusion. There, the evidence respecting the reasons why the plaintiff nurse risk manager was terminated two months after she reported the hospital's alleged EMTALA violation was disputed. The court denied summary judgment for the hospital on the plaintiff's claim that her termination was improper and that reliance on her reported performance shortcomings was pretextual.[6]

The Kaplan case teaches that hospitals accused of improperly sanctioning reporters may have to defend themselves in court. But Kaplan's lessons do not end there.

After the Kaplan trial court adopted the recommendations of the magistrate judge to deny the hospital's summary judgment motion, plaintiffs sought discovery of peer review documents privileged under Maine law. The court refused to apply the state privilege rules to the plaintiffs' federal claim, and, subject to certain restrictions, forced the hospital to produce the documents sought. The hospital asserted that it terminated the doctor and the PA not because they had blown the EMTALA whistle, but because of its "quality of care concerns" regarding them. The plaintiffs countered that this defense was a mere pretext. The court reasoned that the plaintiffs were entitled to test that defense: "For Plaintiffs to have a legitimate opportunity to contest Defendant's contention, access to peer review records of other physicians, which records document performance issues, is essential. In fact, through its defense of Plaintiffs' claims, Defendant has enhanced the need for Plaintiffs' access to the records."[7]

EMTALA SEEKS TO PREVENT IMPOSITION OF NEGATIVE CONSEQUENCES ON PHYSICIANS AND QUALIFIED MEDICAL PERSONS WHO REFUSE TO AUTHORIZE AN UNLAWFUL TRANSFER.

According to the U.S. District Court, District of Maine, then, not only did the Kaplans state a claim that would ground a recovery, but they would be permitted to see sensitive documents that are otherwise sheltered from discovery and maintained confidential.

Who Is Covered by the Whistleblower Provisions?

The first portion of EMTALA's whistleblower clause is straightforward enough: The law seeks to prevent imposition of negative consequences on physicians and QMPs who, in an effort to advance the goals of the law, refuse to authorize a transfer that EMTALA has made unlawfully. But as noted above, EMTALA requires hospitals to provide medical screening examinations, and to stabilize those patients identified as having emergency medical conditions as defined by the law. Under the language of the statute, whistleblower protection appears to be limited to reports of refusals to improperly transfer, and not to reports of other potential EMTALA violations.

The second part of EMTALA's whistleblower protection provides protection for hospital employees reporting not just improper transfers but also any other violation of EMTALA. But the text refers solely to hospital "employees." If a physi-

cian is employed by the hospital, as so many are today, he or she can invoke this clause and either avoid being sanctioned or, if the physician is penalized in some measure for reporting, seek a remedy under the law, as the Kaplans are doing now.

However, even today, many physicians are independent. In particular, many EPs are members of groups that staff EDs as independent contractors, not as employees. Does the law not protect from sanction an independent EP who reports a violation other than an improper transfer?

Ordinarily, judges apply the "plain meaning of legislation" to the fact patterns with which they are presented. Indeed, an excellent argument can often be made that to do otherwise is to exceed the authority of the court. Given EMTALA's purpose, and a concern that to limit whistleblower protection strictly to those actors expressly identified in EMTALA would thwart congressional intent, some courts have concluded that EMTALA's whistleblower protections also extend to non-employed physicians with privileges at the hospital:

"Enforcement of the statute must … depend on those working in hospitals who are in the best position to observe and report EMTALA violations. To find that physicians with staff privileges are not employees for purposes of EMTALA's whistleblower provision would leave unprotected a group of people in an 'advantageous position' to observe and report potential violations. This would be 'demonstrably at odds' with the purpose of the statute ..."[8]

To be protected, in fact, the whistleblower need not even have been personally involved in the care of the patient whose care triggers the report.[9]

Conclusion

EMTALA's whistleblower protections provide substantial protections for health professionals who report potential violations. The statute certainly has its flaws, not the least of which is that it creates an unfunded mandate for the care of the uninsured. Some would argue that it has caused at least as many problems as it has solved. Be that as it may, the case law as it stands now suggests that the drafters succeeded in creating protections for those who report real or suspected violations, even reporters who are not explicitly identified in the text of EMTALA. Both hospitals and professionals should probably assume that, in the event of discrimination litigation, courts will closely scrutinize adverse employment decisions made in the wake of such reports, and may well err on the side of allowing discrimination claims to proceed. ■

BEWARE: IN EMTALA SUITS, COURTS WILL CLOSELY SCRUTINIZE ADVERSE EMPLOYMENT DECISIONS, AND MAY ERR ON THE SIDE OF ALLOWING DISCRIMINATION CLAIMS TO PROCEED.

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ED 'Super Users' at High Risk of Death

Protect yourself legally by addressing patient's chief complaint

Patients who present to EDs frequently are more than twice as likely as infrequent users to die, be hospitalized, or require other outpatient treatment, according to a recent analysis of 31 studies.[1]

"We feel strongly that our results highlight a need to regard frequent ED users as a high-risk patient population in the ED," says **Jessica Moe**, MD, the study's lead author and a resident in the Department of Emergency Medicine at University of Alberta in Edmonton, Canada.

Up to one in 12 ED patients is a frequent user, according to the studies analyzed by the researchers, which defined frequent users as visiting from four to 20 times a year. Some key findings:

• As a whole, frequent ED users are a heterogeneous group of patients spanning a spectrum of clinical risk. This includes high-risk groups such as patients with chronic disease and psychiatric co-morbidities.

"From the outset, we suspected that the aggregate evidence might show a higher risk for adverse outcomes," Moe says. "The strength of the association was larger than expected."

The data showed that frequent users experience a median 2.2-fold increased odds of mortality, 2.58-fold increased odds of admission, and 2.65-fold increased odds of outpatient visits, compared to non-frequent users.

This challenges the view of EPs who consider frequent ED users "nuisance patients" that contribute to overcrowding and who should be deterred from the ED.

"On the contrary, our study shows that these are patients at high risk for adverse outcomes who could potentially benefit from targeted intervention," Moe says.

She urges EPs picking up the chart of a patient who has presented frequently to the ED to pay attention to this pattern as an indicator of increased risk for mortality.

A 2011 SURVEY OF 418 EMERGENCY PHYSICIANS FOUND MORE THAN HALF HAD LESS EMPATHY FOR FREQUENT ED USERS, AND NEARLY THREE-QUARTERS BELIEVED A PROGRAM TO MANAGE FREQUENT ED USERS IS NECESSARY.

"Identifying whether this patient has needs that are currently unmet or that have been incompletely addressed, and linking them with targeted supports, might avert these adverse outcomes and thereby prevent liability risks," Moe suggests.

Targeted Interventions Needed

In a 2011 survey of 418 EPs, 59% reported having less empathy for frequent users than other patients, and 71% believed a program to manage frequent users is necessary.[2] A 2014 study found that the vast majority of so-called "super-frequent user" patients who seek care in the ED have a substance abuse addiction.[3]

"When we calculated how many of our patients demonstrate narcotic-seeking behavior, it was much higher than we would have expected," says **Jennifer Peltzer-Jones**, PsyD, RN who led both studies. Peltzer-Jones is a clinical psychologist at Detroit-based Henry Ford Health System's Department of Emergency Medicine.

In fact, the researchers conducted the 2014 study to disprove the stigma that most frequent ED users are drug-seeking.

"Once we saw the results, we realized how much narcotic seeking does impact frequent ED use," Peltzer-Jones says.

In 2004, EPs at Henry Ford created the Community Resources for Emergency Department Overuse (CREDO) program in response to increased numbers of frequent users in the ED. Once the highest utilizers of the ED are identified, specific plans of care are developed by a multidisciplinary team. Possible interventions include linking patients to community resources and contacting outpatient providers.

"Emergency physicians need this type of assistance," Peltzer-Jones

emphasizes.

Address Chief Complaint

A recent malpractice case involved a 20-year-old male who came frequently to the ED requesting pain medication for back or abdominal pain. On one ED visit, he complained of back pain and reported a history of low-grade fever.

"It turned out he had an epidural abscess, which ultimately resulted in his paralysis. He had so many frequent visits that they didn't work him up," says **Marc E. Levsky**, MD, vice chair of the board at the Walnut Creek, CA-based The Mutual Risk Retention Group. Levsky is also a fellow at PIAA, a Rockville, MD-based insurance trade association, and an EP at Marin General Hospital in Greenbrae, CA.

The plaintiff alleged that the EP failed to meet the standard of care because the patient did not have an MRI of the spine, which would have diagnosed the abscess before the patient had complications.

The defense countered that the patient's vital signs were normal at the time of the ED visit, and that the patient was instructed to follow up in two days but failed to do so until five days later. In addition, the EP documented that the patient had paraspinous tenderness, says Levsky, "which is not usually indicative of a serious etiology. It is considered a benign finding, but its presence doesn't rule out something serious."

Despite these factors in the EP's favor, the case ended up being settled.

"It was considered a high-value case because the claimant — an active young guy who is now paralyzed because of something the EP supposedly did — would be very sympathetic," Levsky explains.

The lesson for EPs, he says, is to pay more attention to frequent ED users, and to document why advanced imaging is not indicated.

Levsky believes that documentation of a frequent ED user presenting multiple times, always asking for pain medications, can help the EP defendant.

> THE LESSON FOR EMERGENCY PHYSICIANS IS TO PAY MORE ATTENTION TO FREQUENT ED USERS, AND TO DOCUMENT WHY ADVANCED IMAGING IS NOT INDICATED.

"The boy who cried wolf is a good defense — as long as there is clear documentation for why you didn't believe imaging was necessary, and that you addressed the chief complaint," he underscores.

ED charts with sparse documentation, such as "Patient always here for pain medicine, here for same, no acute complaints," are not helpful, however.

"Those people will ultimately have a bad outcome at some point," Levsky warns. "Document an appropriate workup, no matter how many times that patient has been to your ED."

The decision as to what constitutes an appropriate workup for the patient should be made independently of the decision to give pain medication or not, Levsky adds.

"It may be appropriate not to prescribe narcotics, but it's never appropriate to dismiss their complaints," he says.

While some state medical board complaints against EPs have involved failure to treat pain, Levsky says this is very unlikely to result in disciplinary action if the EP documents why prescribing would be riskier than not prescribing, after consulting the state's Prescription Drug Monitoring Program and finding a documented pattern of heavy use.

"That would be highly defensible," he says. "It would be very hard to find fault in that medicine."

Levsky is unaware of any cases in which an EP was sued for failing to prescribe narcotics with a documented pattern of overuse, while multiple cases have involved patients who experienced adverse outcomes from pain medications and later sued the prescribing physicians.

Some health systems post signage in their EDs stating, "We do not refill pain medications for chronic conditions."

"It's something the patient can be shown for a reason why we're declining to refill their hydrocodone," Levsky says.

Such a sign is more of a general guideline than a formal policy.

"If you elevate it to the level of a policy, then there is a liability issue if the EP doesn't follow it," Levsky says. ■

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Poor Change-of-shift Communication Triggered Successful Med/Mal Suits

Clear communication needed between the outgoing and incoming ED attending physicians

A patient with a vascular injury was flown from a remote community hospital to a tertiary care center, which accepted her into its vascular surgery service but asked that she first be taken to the ED for further evaluation.

"By the time the patient reached the tertiary care center, almost six hours had passed since the fall that caused her injury," says **W. Ann Maggiore**, JD, an attorney at Butt Thornton & Baehr in Albuquerque, NM.

The patient arrived at the ED close to shift change and remained in the ED for another six hours before the vascular surgeon took her to the operating room. By that time, the popliteal artery had been completely transected, the gastrocnemius and soleus muscles were no longer viable, and an above-the-knee amputation was performed.

"The ED attending whose name was on the chart was named in the lawsuit, but adamantly denied that he had ever seen the patient," Maggiore says.

The attending on the incoming shift similarly denied that she had seen the patient.

"During investigation of the case, no ED attending could be identified as having seen and assessed this patient," Maggiore says.

The first ED attending had billed for seeing the patient, but no documentation of any assessment or notification of the vascular surgery service could be located.

> VITAL SIGN COMMUNICATION IN THE ACADEMIC SETTING WAS POOR AND OFTEN REQUIRED "RESCUE" COMMUNICATION BY A SENIOR RESIDENT OR ATTENDING, OR BY ONCOMING PHYSICIANS' REQUESTS FOR VITAL SIGNS.

"The vascular surgeon had gone home to sleep, expecting to be awakened when the patient arrived, but he was never notified of her arrival," Maggiore says.

Only the ED attending who had billed was named in the resulting malpractice lawsuit, which was settled.

Both the patient's bad outcome and the malpractice litigation could have been avoided, says Maggiore, "with clear and complete communication between the outgoing and incoming ED attending physicians."

Information Not Conveyed

EPs failed to communicate a patient's hypotension or hypoxia in one out of seven handoffs, according to a recent study analyzing 1163 patient handoffs during 130 ED shift rounds.[1]

The fact that vital sign communication in the academic setting was poor and often required "rescue" communication by a senior resident or attending, or by oncoming physicians' requests for vital signs, is "notable," says **Arjun Venkatesh**, MD, MBA, MHS, the study's lead author and instructor at Yale University School of Medicine.

Venkatesh says that EPs should "recognize the patient safety risk introduced by communication errors,

and utilize systems and care transition behaviors that combat this risk."

Handoffs at change of shift are "without a doubt, a higher area of risk. Everyone accepts that," says **Michael B. Weinstock**, MD, adjunct professor of emergency medicine at The Ohio State University College of Medicine and ED chairman at Mount Carmel St. Ann's Hospital in Westerville, OH.

Weinstock contends that formalized handoff checklists are only used by "the rare EP. It's easy to say we should do it, but it is not realistic in the practice of emergency medicine."

He says malpractice cases involving handoffs are often rooted in these risk-prone scenarios:

• A physician assistant is caring for a patient, and the EP they are working with goes off shift.

"The new EP might not even hear about that patient," Weinstock says. "That leaves the midlevel provider hanging out there without adequate backup."

• Toward the end of a shift, EPs might avoid getting "too involved" with complicated patients.

"This is something we don't talk about, but it's the elephant in the room," Weinstock says. EPs may stop seeing patients 30 minutes before the end of their shift, and when the new EP comes on, he or she might not see the patient for an additional 15 to 30 minutes. As a result, the patient might not be seen by any EP until they have been in the ED for 45 minutes to an hour.

"When we are overly concerned about a handoff, and don't see the patient at all, then the patient isn't getting any care," Weinstock says. "This is way more dangerous than a handoff."

• The oncoming EP doesn't perform repeat assessments.

In one malpractice case involving an ED handoff, a 15-year-old girl who presented with right lower quadrant pain became septic and died from a ruptured ovarian cyst, which went undiagnosed. Both the oncoming and offgoing EPs were sued.

> "IT IS IMPERATIVE THAT THE DEPARTING PHYSICIAN ENUMERATE WHAT HAS NOT YET BEEN DONE AND WHAT NEEDS TO BE ADDRESSED BY THE ONCOMING SHIFT."

"At change of shift, the offgoing EP didn't discuss some of the potentially life-threatening problems that had not been addressed," Weinstock says. Also, the EP did not perform a repeat abdominal exam. Weinstock says that oncoming EPs should do these two things when assuming responsibility for a patient from the previous shift:

1. Perform a focused assessment.

"Sometimes patients tell different stories to different providers," Weinstock notes. "It also allows you to see the progression of disease." He says EPs should put a note on the chart stating that they are assuming responsibility for the patient and the results of the focused assessment.

2. Inform the previous EP of the patient's test results and outcome.

This practice encourages outgoing EPs to continue evaluation of patients at the end of their shift, Weinstock says. This is because they are confident the oncoming EP will assume responsibility for the patient.

"They won't wait to order a test because the results won't come back before the end of the shift," he explains.

Amy E. Goganian, Esq., an attorney at Goganian & Associates in Needham, MA, has seen cases in which the oncoming EP failed to ensure that ordered tests actually were performed, or failed to review test results that were placed during the previous shift but haven't come back yet.

"EPs should look for results themselves and note any critical values, rather than assuming the nurse or someone else will bring it to their attention," she says.

A stat MRI ordered by the outgoing EP became a central issue in one malpractice claim that named both EPs.

"The incoming EP was criticized for not aggressively following up and making sure the MRI took place as soon as possible," Goganian says.

In such cases, documentation stating that the plan was discussed with the incoming EP strengthens the outgoing EP's defense.

Incoming EPs can reduce risks by performing their own assessment after receiving the report.

"Possibly, they may pick up something that the outgoing physician did not," Goganian says. "It's not enough to rely on what your predecessor did or ordered."

If the outgoing EP is waiting for test results to determine a patient's disposition, the oncoming EP must be advised of this, "and it is critical that the departing physician chart the handoff," says **David S. Waxman**, JD, an attorney in the Chicago office of Arnstein & Lehr.

Another malpractice case involved imaging ordered by the outgoing EP. The outgoing EP asked an ED nurse to have the incoming EP order the imaging; the incoming EP wrote the order as requested.

The patient was transferred to the floor after the imaging and did not return to the ED.

"In the case against the departing physician, her delegation of the order and failure to follow up on the bleed seen on the imaging comprised much of the case against her at trial," Waxman says. "The incoming physician was almost sucked into the case."

The incoming EP was dismissed only upon his showing that he did not actually take responsibility for the patient, but was merely putting the order in the system as a favor for the departing physician.

Plaintiff attorneys commonly cite the need for an offgoing EP to follow through on their own orders, Waxman notes. Often, these orders will not have been carried out by the time of shift change.

"It is imperative that the departing physician enumerate what has not yet been done and what needs to be addressed by the oncoming shift," Waxman says. ■

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Experts: Wait-time Guarantees Could Get EPs Sued

Benefits exist, but practice must be implemented carefully and thoughtfully

EPs' liability exposure could be increased if they feel pressured to deliver on sweet-sounding promises that lead patients to believe they will receive attention quickly, warns **Lisa Schmitz Mazur**, JD, a partner in the Chicago office of McDermott Will & Emory.

Mazur names this allegation as a primary source of liability risks for EPs: That a patient was harmed because EPs reduced their attention on truly emergent patients to attend to less emergent patients so care would be delivered within the wait-time guarantee timeframe.

"While there are many potential benefits to [posted ED wait times], there seem to be just as many potential risks if this practice is not implemented in a careful and thoughtful way," says Mazur.

Guarantees Are "Bad Idea"

While some hospital administrators view wait-time guarantees as an effective strategy for improving ED throughput, such guarantees "are a bad idea, disconnected from the realities of emergency medicine," asserts **Mark Reiter**, MD, MBA, FAAEM, CEO of Emergency Excellence and residency director at University of Tennessee-Murfreesboro/Nashville. Reiter is also president of the American Academy of Emergency Medicine (AAEM) and authored the organization's 2014 position statement opposing ED wait-time guarantees.

According to the position statement, wait time guarantees "potentially compromise patient care by forcing emergency physicians to reduce their attention on truly emergent patients to ensure that less-emergent patients are seen within the wait time guarantee interval." (The AAEM's complete position statement can be viewed at ***http://bit.ly/1LpaQEU***.)

Reiter is unaware of any malpractice cases specifically involving ED wait time guarantees.

"But I would not be surprised if some had occurred," he says. "Every day, there are EDs that fail to satisfy their internal wait time guarantees."

Some of these patients will experience poor outcomes, and delays in care could be a contributing factor.

Reiter says a plaintiff attorney could allege either of these things:

• That the EP did not provide enough attention to a critically ill patient, in order to satisfy a wait time guarantee on a non-emergent patient;

• That the hospital and EPs failed to ensure there was enough staffing and capacity to deliver care within their guaranteed wait time.

"Any decent EP practicing good medicine will, at times, fail to satisfy an internal wait guarantee," Reiter says. "They appropriately prioritize their time to being at the bedside of their sickest patients."

Reiter adds that wait time guarantees frustrate EPs and nurses who are held to unrealistic expectations and dissatisfy patients because the guarantees are often unmet.

"Or the system is gamed, whereby the busy physician with higher priority tasks provides only a cursory introduction to honor the guarantee, while patients continue to wait afterwards," Reiter explains.

Reiter's opinion is that EDs with wait time guarantees face higher potential liability.

"My advice to EPs working under wait guarantees would be to practice good emergency medicine," he says.

This means focusing time on the critical patients in the ED, even if that means failing to satisfy wait time guarantees on patients that are not expected to be emergent.

Michael Blaivas, MD, FACEP, professor of medicine at the University of South Carolina Medical School and an EP at St. Francis Hospital in Columbus, GA, has seen plaintiff attorneys bring up the ED's wait time promise during malpractice litigation. However, juries won't necessarily hold this against the EP.

> FAILURE TO MEET POSTED WAIT TIMES MAY NOT BE A DEATH SENTENCE, BUT IT COULD RAISE QUESTIONS IN THE MIND OF A JURY ABOUT MISLEADING CLAIMS.

"If the ED is overwhelmed, waiting times can go from an expected 20 minutes or less to three hours," Blaivas notes. "Multiple sick patients present, and one among several who are waiting decompensates and arrests."

The question then becomes whether the patient chose to come to the ED specifically because of the wait time guarantee and would have otherwise chosen a different ED. The plaintiff could strongly suggest this by simply stating, "You have all seen ads from this ED around town saying they guarantee a waiting time of less than 30 minutes."

"If there are such ads on the roads, many jurors might agree," Blaivas says. "All the defense can do is argue that it was probably never seen by the plaintiff."

An ED's failure to meet posted wait times "may not be a death sentence in a case," Blaivas adds. "But it could definitely raise questions in the mind of the jury that maybe a patient or family was misled, and someone has to be responsible." ■

SOURCES

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Don't Overlook Patient's Relevant Medical History

Important details could make the difference between life and death

The patient's previous medical history became a central issue in a malpractice case involving a 41-year-old woman who presented to an ED with new and sudden onset of impaired focusing of her left eye.[1]

The triage nurse noted that the left side of the patient's mouth and her left eyelid appeared to droop, and also documented the patient's history of artificial heart-valve surgery. The patient had been prescribed warfarin but had not taken it for about a year because she could not afford the prescription. After a phone conversation with the on-call ophthalmology consultant, the patient was diagnosed with sinusitis

and discharged home on antibiotics. A CT scan did not disclose any evidence of a stroke, but it revealed the presence of sinusitis. The patient was discharged from the ED with a diagnosis of pupil-sparing third-cranial nerve palsy, with instructions to see the ophthalmologist the following day.

After her symptoms progressed, the patient went to a different ED the following day, and was found to have sustained a mid-brainstem stroke. After a jury trial, the plaintiff received $450,000 in economic damages and $0 in non-economic damages.

"During the next few years, both parties appealed the case on a number of legal grounds," says **Thomas R. McLean**, MD, JD, CEO of American Medical Litigation Support Services in Shawnee, KS. These included the plaintiff's desire to obtain non-economic damages, and the defense's assertion that the patient's failure to receive follow-up care as instructed constituted contributory negligence. Ultimately, the appellate court let the jury's award and the trial court's post-judgment rulings stand.

In this case, McLean says, "the ER physician made a mistake when he ignored the patient's heart valve history and the lack of [warfarin] use. It seems likely that when he discussed the case with the ophthalmology consultant, that he did not mention these facts."

From a medical legal standpoint, says McLean, EPs should take notice of the strong defense that the medical malpractice carrier put on for this physician. However, the defense team's best efforts didn't change the fact that the case appeared to be a clear case of failure to make a proper diagnosis.

"Although the EP had an excellent legal defense team, it still could not make the physician's error go away," McLean notes. The take-home message, according to McLean: "Always provide the standard of care to your patients, and never overlook relevant past medical history."

Failure to Obtain Records

Michael M. Wilson, MD, JD, a Washington, DC-based malpractice attorney, had a case in which much of the litigation concerned the failure to obtain the patient's prior medical records from the local pediatrician. The patient was treated with doxycycline, and had a Stevens-Johnson syndrome reaction.

"The argument was that if the ED physician had taken a more complete history, she would have discerned that the patient was concerned about some mouth nodules, went in to see the pediatrician two weeks previously, was pancultured, with all cultures being negative, and had no intervening change in sexual partner," Wilson says. Therefore, the plaintiff alleged, the doxycycline would not have been prescribed if the ED physician had contacted the pediatrician's office and had the recent records faxed over.

"Even though a complete history is not required, a history that is pertinent to the chief complaint and related symptoms, and is adequate in depth, is required by the standard of care," says Wilson. While this is case-specific, where it is feasible to do so, it may be required to contact the previous treating physician and have at least the recent medical records and labs faxed over.

"Many times patients do not understand the labs or the medical issues, and the only way to obtain an adequate history is to do so by contacting the previous treating physician directly," Wilson says.

Los Angeles healthcare litigator **Damian D. Capozzola**, JD, says it is critical for EPs to take "as complete a history as possible" under the circumstances that apply to a particular ED patient.

"By definition, ED patients are more likely to be compromised in their ability to think or recall clearly," Capozzola says. If there is an adverse outcome and the patient becomes a plaintiff in a lawsuit, the plaintiff's lawyer will likely look to put the blame on the provider for not being adequately sensitive to the patient's contemporaneous inability to contribute accurately to his or her own history.

EPs must diligently document the history in the record, both for positive and negative responses, Capozzola adds.

"If a good history was taken but not documented, at trial the plaintiff will be able to paint the picture that no history or a poor history was taken, contributing to an adverse outcome," he notes. ■

REFERENCE

1. *Reeves v. Healy*, 192 Ohio App.3d 769 (2011).

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CME/CNE QUESTIONS

1. **Which is true regarding frequent ED users, according to a recent analysis?**

   A. Frequent users have less risk of mortality compared to other ED patients because they are screened for emergencies more frequently.
   B. Patients who present to EDs frequently are more than twice as likely as infrequent users to die, be hospitalized, or require other outpatient treatment.
   C. Frequent users are much less likely to be hospitalized.
   D. Frequent users generally do not have chronic disease or psychiatric co-morbidities.

2. **What should oncoming EPs do to reduce legal risks at change of shift?**

   A. Reasonably rely on the assessment performed by the previous EP.
   B. Restrict performance of a focused assessment of the patient to when if symptoms are reported to have worsened since the offgoing EP's assessment.
   C. Do not chart that the EP is assuming responsibility for the patient, as this may be used as evidence.
   D. Document their assumption of responsibility for the patient and the results of a focused assessment.

3. **Which is true regarding wait-time guarantees?**

   A. An ED's wait-time guarantees are generally inadmissable as evidence that an individual EP failed to meet the standard of care, as they are beyond the control of the EP.
   B. Evidence that EPs were under pressure to meet wait-time guarantees strengthens the EP's defense if a bad outcome occurs.
   C. EPs risk exposure to allegations that a patient was harmed because of pressure to focus on less emergent patients at the expense of truly emergent patients.
   D. An ED's wait-time guarantees are generally inadmissible as evidence due to lack promixate of cause of harm.

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