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NOVEMBER 2014 Vol. 25, No. 11; p. 121-132

INSIDE

AHC Media

The Not So Good Samaritan: Assumptions Lead to Liability

By Kevin Klauer, DO, EJD, Chief Medical Officer, Emergency Medicine Physicians, Canton, OH

Health care providers are very fortunate to be compensated while performing a vital public service. However, most are honored to provide volunteer service, giving selflessly to their friends, communities, and often strangers. What could be more rewarding than serving mankind? What are the downsides?

Medical volunteerism may put you at risk for professional liability. That's right; no good deed goes unpunished. Many providers assume that if they act as a "good samaritan," they'll be protected as one. Common misconceptions about "good samaritan" statutes, and the protections they provide, can have disastrous consequences. You simply cannot assume that if you are being altruistic, others won't pursue a claim if they believe you were negligent. Before considering whether or not your state offers "good samaritan" protection, it is of primary and critical importance to recognize whether or not a provider is actually a "good samaritan."

Establishing Duty

The pivotal question to determine whether or not a provider acted as a "good samaritan" is whether or not they owed a duty to the patient. In other words, did they have a duty to act? This is often where legal assumptions are made by those not legally trained. Altruism, in and of itself, does not qualify a provider as a "good samaritan." If a patient-physician relationship is established, duty is established. Although accepting payment for services is the most common way to establish a patient-physician relationship, there are many others. Therefore, you can volunteer (e.g., provide services

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ED LEGAL LETTER

ED Legal Letter™,
ISSN 1087-7347, is published monthly by
AHC Media, LLC
One Atlanta Plaza
950 East Paces Ferry Road NE, Suite 2850
Atlanta, GA 30326.
Periodicals Postage Paid at Atlanta, GA 30304 and at additional mailing offices.

POSTMASTER: Send address changes to:
ED Legal Letter
P.O. Box 550669
Atlanta, GA 30355.

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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.

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This activity has been approved for 15 nursing contact hours using a 60-minute contact hour.
Provider approved by the California Board of Registered Nursing, Provider #14749, for 15 Contact Hours.
This activity is intended for emergency physicians and nurses. It is in effect for 36 months from the date of the publication.

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without compensation) and still establish duty.

In *Velazquez v. Jiminez*,[1] Mrs. Velasquez was an obstetrical patient under the care of Dr. Jiminez. Dr. Jiminez was struggling with the delivery, as the baby had bilateral shoulder dystocia. A page for assistance was made and Dr. Ranzini responded to the request. Dr. Ranzini's efforts to delivery the baby were also unsuccessful. Thus, Dr. Ranzini proceeded to an emergency C-section. The baby was severely brain damaged, presumed due to hypoxemia, and died of pneumonia when he was 2 years old. A lawsuit was filed and the jury returned a verdict for the plaintiffs, apportioning 3% of the liability to Dr. Ranzini. Dr. Ranzini claimed she was a "good samaritan," since she had no prior relationship with the patient. Needless to say, her defense strategy failed.

The following definition is offered in explanation of the verdict.

"In sum, good samaritan immunity … encompasses only those situations in which a physician (or other volunteer) comes, by chance, upon a victim who requires immediate emergency medical care, at a location compromised by lack of adequate facilities, equipment, expertise, sanitation and staff. A hospital or medical center does not qualify under the terms of the Good Samaritan Act in its present form."[2]

It is interesting to note that prior to 1959, no physician had ever been sued for negligent acts while providing care at the scene of an emergency. Following this time, states began drafting "good samaritan" statutes.

Currently, all jurisdictions in the United States have some form of "good samaritan" legislation. However, the scope and content varies from state to state. With respect to coverage within hospitals, some explicitly exclude hospital care, some explicitly include it, and others are silent on this issue. The majority of states fall into this final category, while approximately 11 jurisdictions exclude immunity for hospital care and approximately seven explicitly include it.

Ramirez v. McIntyre, ruled on by the Texas Court of Appeals, stated that Dr. McIntyre, who answered a distress call that a delivery was imminent without a physician present. The baby had shoulder dystocia and was delivered with what was most likely a brachial plexus injury. Dr. McIntyre was sued, but claimed "good samaritan" status due to the fact that he never billed Ms. Ramirez. The court found that "good samaritan" status, and the physician-patient relationship, are not established by actually billing a patient for services rendered, but by the physician's ability to do so. In other words, if a billable service is provided, the Texas Court of Appeals ruled that whether or not the patient is actually billed, immunity couldn't be provided via their "good samaritan" statute.

The few judicial decisions interpreting the category of statutes that neither expressly excludes nor expressly includes in-hospital emergency medical care are in equipoise. On the one hand, cases from Arizona, Indiana and Oklahoma support the proposition that Good Samaritan statutes do not immunize emergency care provided in a hospital to a patient.

In *Guerrero v. Copper Queen Hosp.*, *Steffey v. King*, and *Jackson v. Mercy Health Ctr., Inc*. (Georgia, Illinois, and Utah, respectively), the courts have interpreted their state's good samaritan statutes as protecting physicians who render emergency medical care in a hospital setting.[3,4,5] In *Clayton v. Kelly*, *Johnson v. Matviuw*, and *Hirpa v. IHC Hosps., Inc.,* the difference in outcome between the cases is based, in great measure, on whether the statutes were broadly or narrowly interpreted.[6,7,8]

Despite the former Illinois decisions in favor of protecting physicians who provide emergency care in the hospital setting, a recent Supreme Court ruling has lessened those protections, especially for emergency physicians.

On March 30, 2014, the Illinois Supreme Court ruled against an emergency physician who claimed the "good samaritan" defense. The patient was admitted to the intensive care unit (ICU) with a diagnosis of epiglottitis. The patient experienced a cardiopulmonary arrest. The emergency physician was called to the ICU. Subsequently, he was accused of negligence due to airway management issues and the patient experiencing brain damage. Although his contract stated that he was not to care for non-emergency department patients and he and his group did not bill for the service rendered, his contract also stated that he could provide care to inpatients experiencing "dire emergencies." Thus, the Illinois Supreme Court ruled the physician's response to the in-house emergency was part of his expected duties, and thus, a duty existed.[9]

So what can we take away from this case? Many emergency physicians have contemplated this exact scenario. If you don't bill for services rendered by responding to in-house emergencies, can you be immunized as a "good samaritan?" This case, at least in Illinois, is precedent setting and will make future "good samaritan" claims for services rendered by emergency physicians in the hospital, but outside of the emergency department, ineffectual. Although not binding, other states will likely consider this case when faced with similar facts and asked to contemplate similar questions.

> The court found that "good samaritan" status, and the physician-patient relationship, are not established by actually billing a patient for services rendered, but the physician's ability to do so.

I suspect that many physicians may have already assumed their sense of duty while in the hospital. However, where more confusion exists is what duty exists outside of the hospital. If you volunteer at a first aid station for a marathon, you are the team physician for a high school football team, are asked by a colleague, nurse, or neighbor to "take a look at my child," or answer a call for an in-flight emergency at 30,000 feet, is a duty established? The answer is unequivocally … maybe.

The first step is to reflect on the definition previously provided in the discussion about *Velaquez v. Jiminez*, "In sum, good samaritan immunity … encompasses only those situations in which a physician (or other volunteer) comes, by chance, upon a victim who requires immediate emergency medical care, at a location compromised by lack of adequate facilities, equipment, expertise, sanitation and staff…"[1]

If you apply this definition to the above scenarios, you can see where well-intentioned volunteers establish a duty without realizing they have done so.

In general, there is no duty to rescue a stranger, and the courts favor the approach of preserving autonomous decision and personal liberty over imposing a duty to rescue. In *Buch v. Amory Manufacturing Co.*,[10] a distinction was drawn between a duty to do no wrong is a legal duty, but a duty to prevent wrong is a moral obligation and unenforceable by law.

However, there is clear legal distinction drawn between a responsibility not to make things worse, as opposed to a responsibility to make things better. The former exists and the latter does not. In other words, if you choose to rescue or intervene as a "good samaritan," you are under no obligation to make things better, but you cannot worsen the situation. In *Zelenko v. Gimbel*,[11] the defendant intervened and placed the plaintiff, who was ill, in an infirmary. However,

no care was provided for hours. He subsequently died. The court ruled that in assuming the responsibility for the rescue, the defendant failed to do what a reasonable and prudent person would have done.

For example, if you choose to jump into a lake to save someone and then change your mind and swim back to shore before reaching them, there is no obligation or liability. However, if you attempted to help and made the situation worse, and your actions were not what a reasonable and prudent person would do, liability may be imposed. Trying to help and failing is not what the courts are referring to. In general, if you act in good faith as a reasonable and prudent person, immunity will be preserved. However, if you act recklessly or wantonly, then you are no longer afforded the protections of a "good samaritan." Most statutes reflect this in their language.

For example, Hawaii's "Good Samaritan" statute is noted below.

"Any person who in good faith renders emergency care, without remuneration or expectation of remuneration, at the scene of an accident or emergency to the victim of the accident or emergency shall not be liable for any civil damages resulting from the person's acts or omission, except for such damages as may result from the person's gross negligence or wanton acts or omissions." [12]

For historical purposes, the good samaritan doctrine is included below.

Good samaritan doctrine is a common law doctrine whereby: "a person who voluntarily assumes a duty owed by another and then breaches that duty becomes liable to one who is injured as a result of the breach." The general maritime law requires that the voluntary conduct must be reckless and wanton.[12]

In-flight Emergencies

What are your obligations and protections as a "good samaritan" while on an aircraft? Although beyond the scope of this article, different international jurisdictions may impose different standards. However, in general, and certainly for U.S. carriers departing from and traveling to U.S. destinations, the answers are fairly clear. First, not withstanding any moral obligations to render aid, you have no legal obligation and no duty, unless a prior patient-physician relationship had been established. As an emergency physician, this is a moot point. However, primary care physicians could find themselves in a situation in which they have a duty to aid one of their established patients. However, they would be under no obligation to check the manifest to know such patients may be traveling on the same flight.

With respect to immunity from negligence, great latitude will likely be given in these circumstances. However, there are limits. "Under English law, the standard of care required by a doctor is that set out in the 'Bolam Test,' which is whether in all the circumstances the person acted with the skill and competence ordinarily to be expected from a person undertaking his particular role and professing to have his particular skills — in other words, the skill expected of a reasonable professional."[13]

Ordinary negligence is not the standard in the context of "good samaritan" statues. Thus, errors, in and of themselves, should not constitute negligence while assisting on a flight.

The question of duty often arises in the context of airline generosity. It is not uncommon for an airline to express their gratitude to a "good samaritan" passenger by offering a bottle of champagne or a free upgrade of some kind. So, does this constitute a form of payment and establish duty? Each case would be adjudicated on the individual facts and circumstances of that given case. However, in general, such courtesies do not establish duty. First, the airline, and not the patient, provides the generosity, and second, the "good samaritan" is not usually aware of the generosity extended to him or her until after the services have been rendered. Now, if the bottle of champagne was bartered for, or actual payment for services requested of the patient or the airline prior to or after treatment, this certainly may change the duty required and convert the standard of care to ordinary negligence.

Community and Athletic Events

Where do providers stand with regard to community and athletic events? Although state statues vary, please recall the general premise and intent of "good samaritan" protections, which is the provision of emergency care. "The volunteer event physician who provides non-emergent treatment, such as laceration repair, sprain and strains, or simple fractures, is often not protected by the legislation. Additionally, sports physicals, medical evaluations, or release/return-to-play examinations are

not considered emergency care and do not exempt the provider from liability."[14]

Event liability coverage is for general liability for the event holder and does not cover medical liability. However, physicians may purchase such a policy and may seek reimbursement for the expense. In addition, assisting at such events may be covered under a physician's current professional liability policy, but this must be verified in advance of participation.

With respect to waivers of liability, we all have signed them, but they are largely unenforceable. In general, a general liability waiver notes the individual assumes the risk by choosing to participate in an activity, but cannot waive future liability of a tortfeasor. Let's take bungee cord jumping as an example. Everyone is required to sign a waiver. However, no waiver is allowed to waive the person's right to a claim of negligence against the other party. So, in other words, you cannot construct a waiver insulating you from your negligence. If the bungee cord is faulty and the proprietor should have checked it, the waiver will not and cannot absolve them from their liability. The same is true for events and sports medicine.[14]

Will you be traveling with a youth sports team? You should be cautious, as per a survey performed in 1999, 19 states (AK, CA, HI, IA, IN, ME, MN, ND, NH, NV, NY, OH, OK, OR, SC, SD, VA, WI, and WY) did not allow out of state physicians to practice without a license for the state in which the event would be conducted.[15]

An additional consideration is scope of practice. Physicians considering participating in events should make certain that the anticipated activities will be in the scope of the training and special and current practice. This will reduce the likelihood of an allegation of gross negligence.

For instance, if a pulmonologist, without proper training for trauma, serves as a team physician and does not perform as a reasonable provider would for the care of a spinal injury, recklessness or gross negligence may be alleged. Remember, the care provided would not fall under "good samaritan" protections, as this is a planned event and you accepted responsibility, which may in fact establish a duty to all of those who may be injured.

Imagine compounding this with the assumption that the physician is indemnified by the event planner or professional liability insurance is provided or the physician is covered with his or her own policy. Health care providers are altruistic by nature. However, blind altruism can result in walking into a medical-legal wall. Experience conveys the following observation. People are very appreciative of a physician's willingness to donate their time and expertise. However, if there is a bad outcome, patients often suffer from short-term memory loss, which turns them into plaintiffs.

Be cautious regarding your willingness to help. There is plenty of case law to support a cautious approach with colleagues, neighbors, and friends. When someone asks you for assistance, understand that in the absence of a true emergency, acceptance of the request may be enough to establish duty and a patient-physician relationship. In the absence of usual care, record keeping, and insurance coverage, it may be best to decline. Being a "good person" does not make you a "good samaritan." ■

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Tempted to Give Misleading Info at Deposition? These Claims Against EPs Became Indefensible

Given the soaring stress levels and high stakes of medical malpractice litigation, it's probably not uncommon for an emergency physician (EP) defendant to have a fleeting thought of giving incorrect information during the discovery process. Doing so will quickly backfire, warns **Amy E. Goganian**, JD, an attorney with Goganian & Associates in Needham, MA.

"It is a bad idea to say something that is misleading or inaccurate during discovery, whether through deposition testimony, or interrogatories," she says. "You are arguably committing perjury — although it's tough to prove, the argument can certainly be made."

If the plaintiff attorney is able to show that the EP was untruthful in any way, the EP's credibility is "destroyed," says Goganian. "Nobody wants to be in the position of defending that, because you can't defend it."

Adequate preparation is the key to an EP defendant being an effective witness, she adds. "Don't guess and don't speculate," she says. "If you do not know or do not recall the answer to the question, that is the appropriate response."

Goganian is aware of one case in which an EP claimed in a deposition that he consulted with a specialist about the need for imaging, and that the specialist said it wasn't required. "There was no note of the consult. The specialist the EP allegedly consulted with was deposed and had no memory of ever providing the consult," she says. The case, which was otherwise defensible, was settled.

In another recent malpractice case, a 3-year-old presented with a high fever and appeared to be septic. The EP transferred the child to a pediatric hospital. "The child turned out to have leukemia, which had been missed in the primary care physician's office," says **Bruce Wapen**, MD, an emergency physician with Mills-Peninsula Emergency Medical Associates in Burlingame, CA. "Tragically, the child died."

The EP's medical intervention was criticized as being too slow and inappropriate for the management of sepsis. However, sepsis was never confirmed, nor was it ever proven to be the cause of the child's demise.

The EP's care was defensible, according to Wapen, who served as an expert witness for the defense. During the deposition, however, the plaintiff's attorney asked the question, "Have you ever been investigated by a state medical board?" To which the EP responded "no."

"But the plaintiff's counsel had done their research," says Wapen. The EP was confronted with evidence showing that decades earlier, he had been investigated and disciplined by a state medical board for substance abuse, which the EP then admitted to. "That cost him the case," says Wapen. Once it was confirmed that the EP had lied under oath at the deposition, the defense attorney felt that the case was no longer defensible.

"The case settled for an undisclosed amount," says Wapen. "The lesson here is that a witness may not lie; for if one does, the credibility of that witness is destroyed."

Another EP claimed during his deposition to have examined a patient at triage. "But the entire triage time was captured on video. It showed that he clearly had not examined the patient, as he had not set foot in the area where the patient was," says **Marc E. Levsky**, MD, an EP at Seton Medical Center in Daly City, CA. Levsky is a board member of the Walnut Creek, CA-based The Mutual Risk Retention Group and a fellow at PIAA, a Rockville, MD-based insurance trade association.

This created a very serious problem for the defense. "The EP was forced to settle what was thought to be a case where he would have otherwise been dismissed from the suit," says Levsky. ■

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ED Policies Can Get EP Dismissed in Claim Against PA — or Stuck in the Case

Emergency physicians (EP) can expect to be named in any malpractice lawsuit involving care provided by a physician assistant (PA), but the question then becomes "Will the EP get dropped from the case?"

"Of course we'd all like to see the EP be dropped if the EP did not see the patient. But that will not always be the case," says **John Burton**, MD, chair of the Department of Emergency Medicine at Carilion Clinic in Roanoke, VA.

Burton says these factors typically determine whether the EP will be dismissed from such a claim:

• Did the EP see the patient?

"If the EP saw them, he or she is not going to be dropped," says Burton.

Ken Zafren, MD, FAAEM, FACEP, emergency programs medical director for the state of Alaska and clinical associate professor in the Division of Emergency Medicine at Stanford (CA) University Medical Center was an expert witness in a lawsuit in which the EP was named, but not the PA. The EP signed the chart, and the plaintiff's attorney did not initially realize that the patient had been seen by a PA.

"The PA was on the right track and was derailed by the EP," says Zafren. "The PA was not added as a defendant." In this case, the EP claimed, not very convincingly, to have examined the patient and to have ruled out the eventual correct diagnosis on the basis of his exam. "Many times, people assume that the EP has it right and that the PA was negligent. That is not always the case," says Zafren.

• Does the ED's policy require the EP to see the patient?

Some EDs require EPs to see every patient that the PA sees. "But in my experience, that's pretty unusual," says Burton. "This means many patients seen by the PA aren't seen by the EP, and that there are policies that support that practice."

ED policies should clearly state the expectations for the supervising physician's participation in the care of patients that are seen by PAs, he recommends. "If the policy is that the EPs are not required to see every one of these patients, it's for the physician's gain for the policy to say so very clearly," says Burton.

EPs should ask to see the policy that covers this, he advises. "Where we get into trouble is if the PA and EP are both named in a suit, and the EP did not see the patient, and the policy does not clearly articulate whether the EP has to see those patients," says Burton. "There could be problems in defending the case."

Burton has reviewed dozens of cases involving PAs in the ED setting, "and in every one, the EP has been dropped if he or she didn't see the patient and the ED's policy says the EP isn't required to."

Burton says policies should be general as to which patients the EP doesn't have to see. "As soon as you start getting into specifics around vital signs and chief complaints, it ends up being a slippery slope," he explains.

Since Virginia's statute specifically addresses the oversight of PAs for supervising EPs, Burton uses this exact language in the ED's policy, stating that "The PA cannot solely care for a patient who is unstable."

"It is then the expectation that the PA informs the EP that the patient is unstable, and transfers or co-participates in the care with the EP," says Burton. "We don't go into the details of defining 'unstable.'"

If Burton were practicing in another state, however, he would make the policy less specific, and simply state that the EP is required to participate in the care of any patient when this is specifically requested by the PA or the patient.

"You want to be general around defining who the EP has to see, so the department can flex to meet the needs of that particular shift and the skill mix that it requires," says Burton.

EPs can then truthfully state that they met the expectations as outlined in the hospital policy. "That would hopefully lead the plaintiff attorney to drop the suit," says Burton. "But many EDs do not have clear policies on this, and it creates a liability for EPs."

Some EPs write a note in the chart stating that they did not see the patient and don't agree with the patient's care. "What they are trying to do is say, 'Whatever happens to this patient, I don't have any responsibility for it,'" says Burton. "They believe it will absolve them. In reality, it makes it less likely they'll be dropped."

This type of statement is

indicative of tension involving oversight of PAs in the ED, he explains. "We want the message to be that everyone is on the same team, and meeting their roles as defined by the ED's policy," says Burton.

• Do the EP and the PA have the same insurer?

"If the hospital, the EP, and the PA are all insured by the same company, then there is really no gain for the plaintiff to have more defendants on the case," says Burton. If the EP is kept in the case, the plaintiff attorney has the burden of proof to show that the patient's bad outcome occurred as a result of not being seen by the EP. "So they are better off just making the argument that the PA didn't meet the standard of care," says Burton.

If the EP's group has their own separate policy, however, "there is very clear motivation to keep the EP in the case," says Burton.

In a recent case that Burton reviewed, a tendon injury was missed in a patient with a large forearm laceration. The plaintiff was ultimately unable to undergo surgical repair due to the significant delay in diagnosis. The initial care in the ED was provided by a PA with no physician assessment.

"The PA record was very good, with a physician signing the chart," says Burton. "However, there was no denying the missed injury and subsequent delay to diagnosis in the case." Lack of follow up, which would have created the opportunity to re-evaluate the injury, was clearly a contributing factor.

Both the PA and EP were hospital employees under the same insurance policy. After reviewing the records and an initial discussion regarding the claim, the plaintiff dropped the EP and proceeded with the case against the PA and the follow-up provider. "The eventual outcome was a settlement on behalf of the plaintiff," says Burton. ■

SOURCES

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If ED Nursing Staff Are Stretched Too Thin, EP Faces Legal Risks

If a patient's bad outcome is clearly due to inadequate ED nursing staffing, the emergency physician (EP) on duty could end up being liable, even if he or she provided entirely appropriate care.

"If something is truly not in the EP's control, the EP should not end up being the one that goes down. Unfortunately, in our legal system, under certain circumstances, that can happen," says **Robert Suter**, DO, MHA, professor of emergency medicine at UT Southwestern Medical Center in Dallas, TX.

EPs have little input over how the ED is staffed, he acknowledges, and even ED medical directors who have a responsibility to work with the hospital to assure proper staffing have only limited influence.

"The fact that there are risks for the EP involving staffing really goes under the 'Life's not fair' category in the legal system," says Suter. "If the ED isn't staffed appropriately, the EP faces a difficult choice."

If staffing is not improved, does the EP stop working at the hospital? Or, in the case of a group, should the EP cancel the contract? "These situations are potentially transient," notes Suter. An EP may take a position at a hospital with good staffing, but that can change over time due to a change in administration or ownership.

ED physicians face these legal risks involving nursing staffing:

• The plaintiff attorney can argue that inadequate staffing contributed to the patient's bad outcome.

"If that's the plaintiff's theory, they are going to sue the hospital. But it's very rare that only the hospital will get sued," says Suter. It's likely that the EP on duty will also be named, particularly whoever cared for the patient.

"Even if in retrospect it appears that their care was good, and they had nothing to do with what happened, the EP is probably going to be pulled into it," says Suter.

• The Centers for Medicare & Medicaid Services (CMS) has made it clear that EPs can be held accountable for Emergency Medical Treatment and Labor Act (EMTALA) violations involving hospital-controlled issues.

"CMS has shown this to be true in multiple cases, as unreasonable as it might seem to most practicing EPs," says Suter. This is the case even when the EP is completely unaware that nurses are not doing things in a timely manner, such as bringing back patients, because they're understaffed.

"You could be on duty working very hard and have no idea whatsoever, but CMS may go ahead and include you as the EP on duty in an EMTALA violation," says Suter.

• The plaintiff can use the "captain of the ship" legal theory.

"Attorneys still use this ap-proach to hold the EP accountable for everything that's going on — even when this theory seems ridiculous to anybody who's ever worked in an ED," says Suter.

Suter has seen cases in which the EP was named in a lawsuit where the plaintiff linked the patient's bad outcome in part to poor staffing. Whether the EP is ultimately found to be responsible in such a case depends on the judge or jury. "There have been cases where there was nothing the EP could have done. Yet the judgment could still end up against the EP," says Suter.

EPs typically face tremendous pressure to settle such cases, even when the outcome clearly wasn't their fault. "Those settlements can be large, and they certainly will follow the EP for the rest of their careers, no matter how unfair they were," warns Suter.

This is particularly true if there is a sympathetic plaintiff, because of the cost of defending the claim and the risk that the EP will still be found liable, says Suter, "even in cases where absolutely no liability should be attached to the EP."

EP May End Up Only Defendant

Plaintiff attorneys often don't initially understand who actually controls the ED's operations, and, therefore, may name both the EP on duty and the hospital. In this scenario, it's possible the hospital may quickly step in to make a settlement offer.

"It may be a multimillion dollar lawsuit and the hospital is 100% responsible for the situation, but the hospital settles for a few hundred thousand and is dismissed from the suit," says Suter.

This leaves the "innocent" EP as the sole defendant. "I have seen this before when there is, for example, an injured child and no other defendants. The judge or jury just wants to do something for the plaintiff, and the EP gets stuck with the big verdict," says Suter. "Things like this happen in our legal system all the time." He recommends these practices to reduce legal risks:

• Avoid documenting concerns about nursing staffing in anyone's medical record.

Instead, bring up concerns with the ED medical director or group, but do so with caution. "You do need to be very careful about how you express these concerns," says Suter. "Be very positive and focused on improving patient care and reducing risk for the hospital and your group."

Suter recommends outlining such concerns in an email or letter to the medical director or the hospital's nursing director, such as "I will do everything possible to provide the best care to patients with the staffing resources provided. I understand that ED staffing is not my decision, but I am concerned that at times, we may need more staffing than we have to give the best possible care. I appreciate any efforts to improve the situation and am happy to discuss it further with you."

"Keeping this documentation in a safe place could potentially provide you some protection down the road," says Suter.

• Show patients and family you are doing all you can under difficult circumstances.

"Don't draw their attention to the fact that the ED is understaffed," says Suter. Instead, the EP can state the obvious — that it's very busy and that staff are doing everything they possibly can for all the people who need help. "One of the best risk management tools you have at your disposal is being nice and showing genuine concern," says Suter.

Suter has seen cases in which the EP was not named in a suit specifically because the patient or family had a high opinion of him or her.

"There's always a chance that they will tell the attorney, 'We don't want to sue the ER doctor, because he or she was the one person that was doing everything they possibly could,'" says Suter. ■

SOURCE

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Delayed Triage: "Huge Liability Risk" for Emergency Physicians

Allegations made against a hospital for delaying evaluation and treatment and causing the patient to deteriorate can easily be extended to the emergency physician (EP), says **Kathleen Shostek**, RN, ARM, CPHRM, senior consultant in the health care risk management and patient safety division of Sedgwick, a Memphis-based third party administrator for professional liability claims.

One such case included allegations of negligent triage, resulting in a delay in the EP's examination of a patient with chest pain, resulting in the patient's death in the emergency department (ED).[1] "The urgency of the patient's condition was not conveyed to the physician. Thus, the patient's evaluation was not performed timely," says Shostek. The case settled for $584,000.

In another case with a similar fact pattern, the plaintiff argued that the hospital failed in its duty to enforce adequate rules and policies with respect to the triage of ED patients, patient admission, and shift changes.[2] The plaintiff also alleged the EP failed to timely diagnose and treat her evolving stroke, as well as lack of hospital oversight of patient care in the ED. "On appeal, the court reversed and remanded the case for a new trial against the hospital on corporate negligence grounds, and reinstated negligence claims against the EP, ordering he be reinstated as a defendant in the new trial," says Shostek.

Triage "Even More Critical to the Process"

Staffing pressures on EDs have "dramatically increased" due in part to the Emergency Medical Treatment and Labor Act (EMTALA), according to **Richard F. Cahill**, Esq., vice president and associate general counsel at The Doctors Company, a Napa, CA-based medical malpractice insurer.

"As a result, triaging has become even more critical to the process," he says. More adverse outcomes and resulting malpractice lawsuits are likely to occur due to inadequate training of ED personnel and improper triage procedures, warns Cahill.

"The Patient Protection & Affordable Care Act aspired to correct this dangerous trend, and to redirect patients to primary care physicians from hospital EDs," he says. However, the projected enrollment under the Act will likely not alter the current pattern of treatment decisions by the underserved population any time in the foreseeable future, says Cahill.

If ED nurses are inadequately trained for triage, with less than one year of experience, this increases the risk of malpractice claims, says Shostek. "Also, nurse managers may not really know what their nursing hours per patient visit are, and that affects staffing," she adds.

Inadequate staffing to adequately manage the peak volume times in the ED results in delays and backlogs, says Shostek.[3] "When a patient is not triaged timely and accurately, the delay can negatively affect clinical care and outcomes," she says. "This is a huge liability risk for both the hospital and the EP."

Shostek recommends these two approaches to reduce liability risks involving ED staffing:

- **The ED medical director should collaborate with the hospital to implement an effective triage system.**

"This includes experienced nurses or providers with validated triage skills, and adequate overall staffing to meet the needs of ED patients," says Shostek.

- **ED staffing policies should include a contingency plan for additional physician and nurse staffing when patient care demands exceed available staffing resources.**

"This can include a per-diem pool or on-call plan," says Shostek. ■

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United States Postal Service

Statement of Ownership, Management, and Circulation

1. Publication Title	2. Publication Number	3. Filing Date
ED Legal Letter	1 0 8 7 – 7 3 4 7	10/1/14
4. Issue Frequency	5. Number of Issues Published Annually	6. Annual Subscription Price
Monthly	12	$519.00

7. Complete Mailing Address of Known Office of Publication *(Not printer) (Street, city, county, state, and ZIP+4)*
950 East Paces Ferry Road NE, Ste 2850, Atlanta
Fulton County, GA 30326-1180
Contact Person: Robin Salet
Telephone: 404-262-5489

8. Complete Mailing Address of Headquarters or General Business Office of Publisher *(Not printer)*
950 East Paces Ferry Road NE, Ste 2850, Atlanta, GA 30326-1180

9. Full Names and Complete Mailing Addresses of Publisher, Editor, and Managing Editor *(Do not leave blank)*

Publisher *(Name and complete mailing address)*
AHC Media LLC, David Fournier, President and CEO
950 East Paces Ferry Road NE, Ste 2850, Atlanta, GA 30326-1180

Editor *(Name and complete mailing address)*
Shelly Mark, same as above

Managing Editor *(Name and complete mailing address)*
Leslie Hamlin, same as above

10. Owner *(Do not leave blank. If the publication is owned by a corporation, give the name and address of the corporation immediately followed by the names and addresses of all stockholders owning or holding 1 percent or more of the total amount of stock. If not owned by a corporation, give the names and addresses of the individual owners. If owned by a partnership or other unincorporated firm, give its name and address as well as those of each individual owner. If the publication is published by a nonprofit organization, give its name and address.)*

Full Name	Complete Mailing Address
AHC Media LLC	950 East Paces Ferry Road NE, Ste 2850, Atlanta, GA 30326-1180

11. Known Bondholders, Mortgagees, and Other Security Holders Owning or Holding 1 Percent or More of Total Amount of Bonds, Mortgages, or Other Securities. If none, check box → ☒ None

Full Name	Complete Mailing Address

12. Tax Status *(For completion by nonprofit organizations authorized to mail at nonprofit rates) (Check one)*
The purpose, function, and nonprofit status of this organization and the exempt status for federal income tax purposes:
☑ Has Not Changed During Preceding 12 Months
☐ Has Changed During Preceding 12 Months *(Publisher must submit explanation of change with this statement)*

PS Form **3526,** October 1999 *(See Instructions on Reverse)*

13. Publication Title: ED Legal Letter			14. Issue Date for Circulation Data Below: September 2014	
15. **Extent and Nature of Circulation**			**Average No. Copies Each Issue During Preceding 12 Months**	**No. Copies of Single Issue Published Nearest to Filing Date**
a. Total Number of Copies *(Net press run)*			125	108
b. Paid and/or Requested Circulation	(1)	Paid/Requested Outside-County Mail Subscriptions Stated on Form 3541. *(Include advertiser's proof and exchange copies)*	93	83
	(2)	Paid In-County Subscriptions Stated on Form 3541 *(Include advertiser's proof and exchange copies)*	0	0
	(3)	Sales Through Dealers and Carriers, Street Vendors, Counter Sales, and Other Non-USPS Paid Distribution	2	3
	(4)	Other Classes Mailed Through the USPS	7	8
c. Total Paid and/or Requested Circulation *[Sum of 15b. (1), (2),(3),and (4)]* ▶			102	94
d. Free Distribution by Mail *(Samples, compliment ary, and other free)*	(1)	Outside-County as Stated on Form 3541	6	4
	(2)	In-County as Stated on Form 3541	0	0
	(3)	Other Classes Mailed Through the USPS	0	0
e. Free Distribution Outside the Mail *(Carriers or other means)*			7	5
f. Total Free Distribution *(Sum of 15d. and 15e.)* ▶			13	9
g. Total Distribution *(Sum of 15c. and 15f)* ▶			115	103
h. Copies not Distributed			10	5
i. Total *(Sum of 15g. and h.)* ▶			125	108
j. Percent Paid and/or Requested Circulation *(15c. divided by 15g. times 100)*			89%	91%

16. Publication of Statement of Ownership
☑ Publication required. Will be printed in the November 2014 issue of this publication. ☐ Publication not required.

17. Signature and Title of Editor, Publisher, Business Manager, or Owner: *David R. Fournier* Publisher & CEO — Date: 09/10/2014

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PS Form **3526,** October 1999 *(Reverse)*

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SOURCES

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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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CNE/CME QUESTIONS

1. **Which is recommended regarding emergency department (ED) policies on patients cared for by physician assistants (PAs), according to John Burton, MD?**

   A. ED policies must require emergency physicians (EPs) to see every patient that the PA sees.
   B. ED policies should clearly state the expectations for the supervising physician's participation in the care of patients seen by PAs.
   C. ED policies should list specific vital signs and chief complaints when delineating which patients the EP has to see.
   D. ED policies should always define the term "unstable."

2. **Which is true regarding claims against an EP involving care provided by a PA?**

   A. If the EP saw the patient, he or she is much more likely to be dropped from the case.
   B. Documentation stating that the EP doesn't agree with the patient's care is legally protective for the EP.
   C. If the EP and the PA have the same insurer, there is an added financial incentive for the plaintiff's attorney to keep the EP in the case.
   D. If the EP is kept in the case, the plaintiff attorney has the burden of proof to show the patient's bad outcome occurred as a result of not being seen by the EP.

3. **Which is true regarding malpractice claims and ED staffing, according to Robert Suter, DO, MHA?**

   A. If a bad outcome occurs due to inadequate ED nursing staffing, the emergency physician (EP) on duty could end up being liable, even if the care provided was entirely appropriate.
   B. If staffing is truly not in the EP's control, the EP cannot be held liable for a bad outcome related to inadequate staffing.
   C. The plaintiff attorney cannot argue that inadequate staffing contributed to the patient's bad outcome.
   D. EPs can be held liable for a bad outcome resulting from inadequate staffing only if the EP had control over the ED's staffing.

4. **Which is recommended for EPs to reduce legal risks involving staffing, according to Suter?**

   A. Clearly document concerns about nursing staffing in medical records.
   B. Outline concerns in an email or letter to the medical or nursing director.
   C. Avoid putting concerns involving staffing in writing under any circumstances.
   D. Make patients and families aware that the ED is understaffed.