ED LEGAL LETTER™

THE ESSENTIAL RESOURCE FOR EMERGENCY MEDICINE MALPRACTICE PREVENTION AND RISK MANAGEMENT

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INSIDE

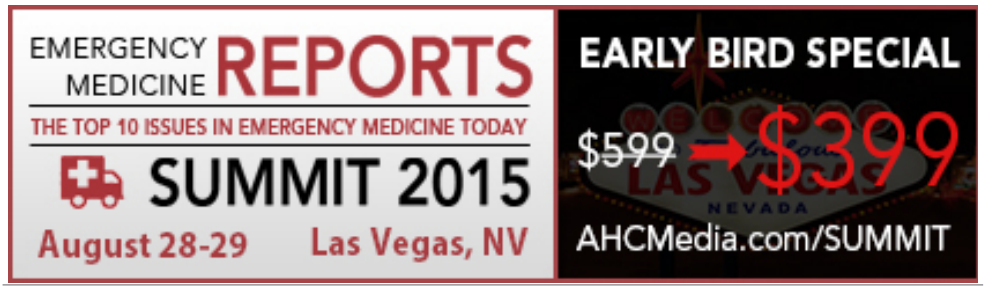
It's Not Enough to Prove Standard of Care Was Reached

Legislation curtails plaintiff attorneys' ability to misuse guidelines

If during the course of medical malpractice litigation, a plaintiff attorney discovers that the emergency physician (EP) defendant didn't receive a Medicare bonus payment for having met a certain quality standard, does this constitute proof that the EP failed to meet the standard of care? What if Medicare did not reimburse the hospital for a portion of the emergency department (ED) care due to the patient's hospital-acquired infection?

EPs are "in the same boat as all other physicians" when it comes to the issue of whether a physician's record on achieving quality metrics can be used as evidence in proving medical malpractice, **William M. Mandell**, JD, an attorney at Boston-based Pierce & Mandell, says. With the passage of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) in April 2015, he adds, "a new standard for the relationship between quality metrics and proof of physician malpractice has been established on a national scale."

The legislation ensures that federal healthcare metrics and reimbursement guidelines are not misused in court to prove allegations of medical negligence. The Affordable Care Act (ACA) established many new payment initiatives utilizing quality metrics. "But the ACA does not include any liability shield for doctors," says Mandell. "Since the enactment of the ACA, some states



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have passed liability shield laws for physicians."

Under MACRA, physicians will be rewarded for providing better quality medical care. Beginning in 2019, a new Merit-based Incentive Payment System will reimburse physicians according to their scores on various quality measures. "There is a provision that prohibits plaintiffs from using a physician's performance on federal quality measures as the sole basis to prove negligence in a medical malpractice lawsuit," Mandell says. This states that "the development, recognition, or implementation of any guideline or other standard under any federal health care provision shall not be construed to establish the standard of care or duty of care owed by a healthcare provider to a patient in any medical malpractice or medical product liability action or claim." [1]

Malpractice attorneys can no longer assert a negligence claim against a doctor on the sole basis that he or she did not earn an incentive or was penalized under any federal healthcare guideline or standard. "Before the passage of MACRA, the medical community was very concerned about the use of quality metrics evidence by plaintiffs as a basis to assert that a doctor committed negligence," Mandell explains.

Information Could Unduly Influence Jury

The effort to pass the legislation began five years ago, according to **Mike Stinson**, director of government relations for PIAA, a Rockville, MD-based industry trade association representing medical professional liability insurers. "We heard reports that some attorneys were taking a look at the paperwork from Medicare; if there was anything that Medicare didn't pay for, then they would encourage the patient to file a lawsuit," he says.

Medicare does not reimburse hospitals for costs associated with "never events" identified by the Centers for Medicare & Medicaid Services, such as hospital-acquired infections. "We wanted to make sure that while people focus on ways to improve, we're not getting failure to meet a certain quality standard confused with negligence," Stinson says. "It occurred to us that while these may be decent quality measures, they weren't aligned with the definition of negligence," Stinson says.

A systemic error, or simply an unanticipated bad outcome, could have occurred.

"Our concern is that it can be a pretty influential thing to say the physician didn't meet a quality metric. This could unduly influence a jury," Stinson says.

Plaintiff attorneys didn't want to see the reverse scenario used against them in court, with defense attorneys using the fact that Medicare paid for the care to prove there was no negligence involved. "We came to a mutual agreement that the status quo in terms of the standard of care should remain in effect," Stinson says. "Efforts to measure quality and determining reimbursements shouldn't be interpreted as evidence that the standard of care was either met, or was not met."

There was no evidence that the quality measures were ever intended to be considered as a legal standard of care, Stinson notes.

"If they have other ways of demonstrating negligence, they can go about proving it the old-fashioned way," he adds. "We just weren't going

to give them a shortcut, especially if it would lead the jury to the wrong conclusion."

Facts Can Still Be Introduced

Plaintiff attorneys can still find ways to bring up an EP's failure to meet a quality standard during malpractice litigation. "That is the tricky part for defense attorneys. But we have given them a tool to back up the argument that the standards aren't supposed to be interpreted or used that way," Stinson says.

Mandell says MACRA allows providers, including EPs, to strive to achieve quality metrics without fear that a failure could constitute breach of the standard of care in a malpractice lawsuit. The MACRA liability protections, however, do not totally prevent the introduction of these facts into evidence in a medical malpractice case.

"It certainly does not go as far as legislation that has been sought by many medical associations," Mandell says.

Such legislation would have provided immunity from liability and other civil suit protections for doctors who are sued and who can prove they followed any evidence-based clinical guidelines.

Some quality metrics are tied to cost considerations more so than the quality of clinical care, **Denny Maher**, JD, MD, director of legal affairs at Washington State Medical Association in Seattle, emphasizes. "Guidelines are more closely related to quality of clinical care, but still represent treatment in a typical or ideal scenario," he adds. "Clinical guidelines don't necessarily take into account unique aspects of a patient's presentation to the emergency room."

In Washington state, for example, there are a number of clinical guidelines established by various state agencies. However, expert testimony is required to establish whether a physician's actions are within the standard of care in a medical malpractice action.

"Because of the unique circumstances under which ED patients present, it behooves every emergency physician who exercises his or her professional judgment in treatment to document the reasons for any variance from any applicable quality metrics or clinical guidelines," Maher advises.

If the EP has a reason for not following any sort of written guideline or ED policy, "in my view, you should absolutely, positively document it," says **Robert J. Milligan**, JD, an attorney at Phoenix, AZ-based Milligan Lawless. "Otherwise, the plaintiff can say, 'Not only did you violate the policy — you didn't even know about it.'"

Avoid Imperatives

The move toward evidence-based medicine and standardized orders is leading EDs to develop many more internal standards and policies, Milligan notes "and those get put in writing somewhere."

If a given standard is possibly relevant to a malpractice case, the fact that the EP met the standards "is of relatively little value for the physician—a plaintiff can argue, 'big deal,'" Milligan says. But if the EP fails to follow the standard, this can be quite damaging to the EP's defense.

"Guidelines are of much more value to the plaintiff's lawyers than they are to defendants," Milligan says "It's very easy to get beaten about the head with them, but very hard to gain an advantage."

Milligan advises against EDs using the terminology "standards" to refer to protocols and guidelines. Instead, he offered the phrase "suggested management of typical presentations."

"One, it is only a suggestion, and two, you can argue about whether the presentation was typical," he explains. "That gives you a little bit of room to maneuver."

An ED's policies should be reasonable and not aspirational, Milligan adds, and should avoid imperatives such as stating that "all patients will be seen within 30 minutes."

"Policies might instead state, 'It will be our goal to see most patients within X period of time," or "absent high volume, it will be our goal,'" Milligan says. ■

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Without Rationale in Chart, Defense of Discharge Claims Becomes Complicated, Experts Say

"Easily relatable to jury"

"Bowel obstruction, meningitis, encephalitis, TIA, stroke, subarachnoid hemorrhage, malaria, sepsis, bacteremia, pneumonia, influenza, appendicitis, cholecystitis, and pyelonephritis, amongst others." In the chart, the emergency physician (EP) then went on to explain why he ultimately believed the patient had stomach flu.

"It was one of the most helpful chart notes I've ever seen in the context of an emergency department [ED] lawsuit," **Jennifer K. Oetter**, JD, an attorney at Portland, OR-based Williams Kastner, says. The case was voluntarily dismissed.

The documentation so thoroughly countered the claim's allegations that the plaintiff's attorney suspected the EP had altered the chart. There were multiple requests for production of all versions of the chart, including metadata for the dictation to try and find an electronic footprint that showed the dictation was altered.

"We were able to locate the audio of the original dictation to prove, definitively, that the chart note had not been altered," Oetter recalls.

Cases Difficult to Defend

The two abnormal vital signs Oetter sees come up most often in ED litigation are elevated temperature and elevated heart rate. "These 'abnormal' findings can be completely innocuous, or they can be non-specific signs of anything from stomach flu to meningococcemia," she notes.

What makes them difficult to defend is that they are "easily relatable to a jury," Oetter says. "A juror understands that a high temperature and high heart rate are not good things." When the patient's chart indicates any abnormal vital signs, she explains, "it is easy to get them to follow a logical path of 'that should have been enough to cause the emergency room provider to do more.'"

A recent malpractice case involved a 50-year-old woman who presented to an ED reporting a terrible headache. "The emergency room physician saw the patient after she waited more than two hours; she had vomited in the waiting room," **Robert D. Kreisman**, JD, a medical malpractice attorney with Kreisman Law Offices in Chicago, says. During an examination, the doctor noted that she had been in the hospital just days before, and diagnosed with a benign brain tumor.

The treating neurologist told the ER physician the woman had an appointment to see a neurosurgeon in several days.

"She had an elevated heart rate, respiratory rate, and blood pressure. The ER physician discharged her with a heavy dose of [meperidine] and a prescription for pain relief medication," Kreisman says. The woman died at home that night of brain herniation related to the diagnosis of the benign brain tumor; the case against the EP was settled. "Had the emergency department staff and physician addressed her abnormal vital signs and symptoms, she would have likely survived," Kreisman says.

Unaware of Final Set of Vitals

Oetter has seen plaintiff attorneys exploit the fact that EP defendants are often unaware of the final set of vitals. At deposition, attorneys almost always ask the EP, "If you had known about that last set of vital signs, would you have done anything differently?" Oetter explains, "The most honest answer is almost always 'I don't know.'"

It can strengthen the EP's defense if ED nurses documented that the EP was aware of the abnormal vital signs and that it does not change the EP's evaluation. "For the physician, the most powerful gift they can give to their lawyer is a thorough chart note that includes, in the section for 'plan,' acknowledgement of the abnormal vitals," Oetter says. Ideally, the EP also includes a list of things that those vitals caused them to consider.

Most malpractice suits against EPs involve one or more abnormal vital signs, according to **John Davenport**, MD, JD, physician risk manager of a California-based HMO. "There are innate legal risks of ignoring or at least not explaining why a 'vital sign' is not normal," he warns.

In one such case, a 63-year-old woman fell from a ladder while trimming bushes in her back yard. She presented to an ED complaining of left chest wall pain and dizziness.

"Her blood pressure was noted as 'normal' at 105/75," Davenport says. An X-ray revealed a rib fracture, and doctors discharged her on pain medications. A few hours later, she collapsed at home and arrived at another ED with a ruptured spleen. "At trial, one of the allegations was that the fact that she was a poorly controlled hypertensive patient on multiple medications who had not had a normal blood pressure in years," Davenport says.

The plaintiff argued that this should have put the EP on notice that the "normal" blood pressure was abnormally low for this patient. "The verdict was for the plaintiff for a substantial amount," Davenport says.

To an EP, the term "vital sign" describes a collection of data that is sometimes useful in diagnosis and treatment, Davenport says, but to a layperson, the term has broader, possibly misleading implications. "The term is mundane to us. But to a jury, the term 'vital signs' likely takes on a larger import, influencing the jury more so when one is abnormal," Davenport says.

He offers these risk-reducing practices:

• Document a follow-up plan for abnormal vital signs.

"If a patient is discharged with high blood pressure, for instance, document that the patient has been told and agreed to follow up with his or her physician in an appropriate time frame," Davenport says.

• Evaluate the vital signs in context.

The EP might chart, for example, "The patient's pulse is 98, but that is consistent with pain." Conversely, Davenport says, "blood pressure of 110/70 may seem wonderful in an ER patient, but not when the patient is a poorly controlled hypertensive with a series of outpatient blood pressure readings in the 150/100 range."

• Be sure that automatically inserted notes in electronic medical records (EMRs) don't conflict with the documented data in the chart.

"Blocks of text may be inserted to save the physician time," Davenport says. "It is therefore important to review blocks of text for accuracy before the physician completes the chart."

For instance, a note which automatically enters, "Vital signs reviewed and normal," may conflict with an ED patient's actual vital signs noted elsewhere in the chart. "Even if the discrepancy is without clinical significance, the fact may be offered at trial to infer that you are, at best, sloppy — and at worst, not truthful," Davenport says.

• When vital signs are abnormal, recheck them and document it.

"This confirms the appearance of someone who is diligent and careful in his or her care of the patient," Davenport says. ■

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Obesity a Factor in 8% of Closed ED Claims

A morbidly obese patient's body fat may not allow an ED physician to accurately palpate for a mass or other condition; some patients cannot undergo some radiological studies due to their size. This doesn't equate to malpractice — even if a bad outcome occurs, according to **Linda M. Stimmel**, JD, an attorney at Wilson Elser Moskowitz Edelman & Dicker in Dallas.

"As an ED physician, you may not be able to complete the assessment you need. That is not malpractice," Stimmel says. "You can only accomplish what is reasonable in the situation."

However, Stimmel notes, it is imperative to chart the decisions or lack of treatment that may be associated with a particular obese patient. "Detail why a certain test was not performed. Chart your analysis, and the restrictions you are faced with regarding this obese patient," Stimmel advises.

The Doctor's Company, a Napa, CA-based medical malpractice insurer, recently analyzed 332 emergency medicine claims that closed from 2007 to 2013. In 8% of claims, obesity was a factor in the outcome; 76% of cases involving obesity had a diagnostic-related allegation. (The complete study is available at www.thedoctors.com/emergencymedicinestudy.)

Here are some examples of obesity-related ED claims:

• A patient who presented with shortness of breath and an oxygen saturation level of 92% waited in the waiting room for five hours.

The patient died of a pulmonary embolus.

• A patient presented complaining of knee pain after a long plane trip and left with a diagnosis of knee ligament strain. The patient died shortly thereafter from a pulmonary embolus.

• Doctors treated a patient with intense pain due to kidney stones with opioids and discharged her home where she died in her sleep, due to the effects of opioid suppression of the respiratory center and undiagnosed sleep apnea.

"We code obesity as a comorbidity only when we see a link between the outcome of care and their obesity," says **Darrell Ranum**, JD, CPHRM, vice president of patient safety and risk management at The Doctor's Company.

Many of the cases in which obesity was coded as a comorbidity involved risk factors that increased due to obesity, but were not adequately addressed. This was seen in cases of hyperlipidemia, hypertension, diabetes, and increased risk of deep venous thrombosis, myocardial infarction, and stroke.

"It appears from reviewing these cases that physicians must factor the risks of obesity into their differential diagnosis, because it does increase risk of having one of these clinical problems," Ranum says. Most of the cases in which diagnosis was alleged to be incorrect were due to physicians not addressing the increased risk that obesity represents for conditions like pulmonary embolism or cardiac damage, he adds.

Stimmel has defended healthcare providers in medical malpractice cases in which the patient was morbidly obese. Here are some common allegations in these claims:

• The ED physician didn't do a thorough history and examination.

"Be detailed in your initial examination and in triage," Stimmel says. "The history of such a patient is critical." The morbidly obese patient, many times, will have several co-morbid conditions that may affect the ED assessment and treatment. "The ED physician can be at risk by not asking the right questions that may disclose a risk that could impede the treatment," Stimmel says.

• The ED didn't have appropriate equipment.

Stimmel says EDs should be equipped with "reasonable" equipment for the general patient population. If there is not an appropriate bed or MRI in your ED for a morbidly obese patient, Stimmel suggests taking these two steps:

-Research other facilities that may be better equipped to handle this type of patient. "So there will be no EMTALA [Emergency Medical Treatment and Labor Act] concerns, have your administration work with other back-up facilities for a transfer agreement," Stimmel says.

-If there are no such back-up facilities in your area, alert the police or paramedics of your ED's limitations regarding morbidly obese patients.

If the ED equipment is reasonable for the general population and the ED can document efforts to have other facilities serve as back up, Stimmel says, "an ED physician should not be held liable for lack of sufficient equipment to take care of morbidly obese patients."

• The ED physician failed to complete a thorough skin assessment.

If a patient's decubitus ulcer is not described in the chart, plaintiff attorneys may use this as evidence that the ED physician did not complete a thorough examination. "If the skin assessment is relevant to the patient's condition, make sure it is well-documented," Stimmel says. "This is a greater liability risk in areas of long-term care than in the ED. But it needs to be noted in the ED exam if it is relevant."

• That appropriate tests weren't obtained due to the patient's size.

Michael Blaivas, MD, FACEP, professor of emergency medicine at University of South Carolina Medical School and an ED physician at St. Francis Hospital in Columbus, GA, has seen EPs forego lumbar punctures or lower extremity ultrasounds to rule out a deep vein thrombosis on obese patients.

In some cases, EPs convince the patients to decline such testing. "However, if a family member or the patient recall such a discussion and can elaborate that they were steered away or scared off by the EP, this can be very challenging to deal with," Blaivas says.

Blaivas is aware of cases involving over-sedation of obese patients. "As we know, some meds are specifically absorbed into fat and then redistribute. This can mean unexpected prolonged sedation in obese individuals," he says. Additionally, the incidence of sleep apnea is very high. "When you combine the two, you are at risk for over-sedation and airway loss. That is exactly what happens from time to time," Blaivas says, noting the best practice is for EPs to

know the effect of medications in obese patients. "Be aware of more likely diseases such as heart disease and sleep apnea," Blaivas adds.

Obese patients often have comorbidities such as diabetes, hypertension, cardiac and circulatory issues, pulmonary issues, and face greater risk when intubation is necessary in the ED, says **Leilani Kicklighter**, RN, ARM, MBA, CHSP, CPHRM, LHRM, principal of the Tamarac, FL-based Kicklighter Group. "Providing an IV line can be particularly difficult," she says.

In an emergent situation, obtaining the weight of a morbidly obese patient can be very difficult as normal scales cannot be utilized; weight-based medical dosages may need to be estimates. "Detailed documentation of the ER physician's thought process and circumstances of the patient's injury or condition is very important, should allegations of negligence be asserted," Kicklighter says.

A general risk-reducing practice is to simply treat obese patients as well as you treat other patients. EPs might tell patients, for instance, "We may not be able to see this as well as we would like," or "This may be a little harder due to your size."

"Many obese patients realize their weight brings limitations," Blaivas says. "In a polite way, discuss the challenges with the patient. Let them know you are trying, that you care, and that you and the hospital will do their best." ■

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Help Defense Attorney to Attack Credibility of Plaintiff's Expert Witness

The most effective way for a defense expert to attack the credibility of an opposing expert at trial is to give testimony that convinces the judge or jury that the plaintiff's expert is wrong, according to **Ken Zafren**, MD, FAAEM, FACEP, EMS, medical director for the state of Alaska and clinical professor in the Division of Emergency Medicine at Stanford (CA) University Medical Center.

"This can include citing relevant literature. But often, the best technique is to explain why the opposing expert is wrong in nonmedical terms," he adds.

For example, testifying on behalf of the defendant in a frostbite case, Zafren rebutted the theory of the plaintiff's expert that rewarming the patient's frostbitten feet would have improved the outcome. Zafren explained to the judge why the evidence showed that the feet had thawed prior to the patient being in custody. The judge granted summary judgment for the defendant, the U.S. Marshall Service.

The outcome of many malpractice cases involving emergency department (ED) care will depend on the abilities of the experts to convince the judge or jury of the validity of their opinions, and/or their interpretation of the facts of the case. "It is part of an expert's job to review the opposing expert's credentials, including education, training, and experience," Zafren says.

Role of EP Defendants is Limited

The defense expert should educate the attorney thoroughly about the issues in the case and the likely theories of the opposing expert, so that the attorney can effectively cross-examine the opposing expert. Emergency physician (EP) defendants, however, should proceed with caution in terms of how much input they provide.

"The defendant emergency physician should not be doing these tasks. The defendant emergency physician cannot be an effective expert, because an effective expert must be unbiased," Zafren says.

An effective expert should know all the relevant literature, educate the attorney, and suggest additional experts, if necessary, to complement his or her area of expertise. "For medical malpractice cases involving emergency physicians, when the experts on both sides are well-qualified, it is generally not a wise idea to attack the credibility of an opposing expert. This move will likely backfire," Zafren says.

An EP's interaction with his or her own defense counsel can vary

quite a bit, notes **John Burton**, MD, chair of the Department of Emergency Medicine at Carilion Clinic in Roanoke, VA. In some cases, the defense attorney or firm may be very interested and inviting toward the defendant EP's preferences, suggestions, and relevant arguments.

"If one is a defendant in a case, one should explore the relationship a bit before jumping into assumptions as to the amount of input one will have in one's own case," Burton says.

Pulling relevant literature, specifically published journal articles, is generally not a good idea for the EP defendant, according to Burton. This is because anything presented to the defense team becomes a discoverable element.

"Since the physician defendant is not an attorney, the construction of the defense should be left up to the expertise of the defense counsel," Burton says. Although well-intentioned, articles produced by the defendant EP might ultimately become damaging to the strategy and positions taken to defend the case.

Here are some things defendant EPs can do to strengthen the defense of a malpractice claim and refute testimony by the plaintiff's expert witness:

• Suggest an expert witness for the defense to consider in reviewing the case.

The EP may be aware of a certain individual with relevant expertise. Burton is occasionally asked to review a case by defense attorneys who were referred to him through defendant EPs who attended presentations he's given on procedural sedation in the ED setting, or are aware of peer-reviewed research he's published on the topic. "This referral process for both plaintiff and defense inquiries to serve as an expert is not uncommon for a subject matter expert in the field of emergency medicine," he says.

• It is helpful for the defendant EP to read the deposition given by the plaintiff's expert.

This allows the EP to understand the plaintiff's position. He or she can then suggest issues of relevance or contention to the defense team. "Again, one has to be cautious not to become overly involved personally in rebutting the plaintiff's position in the deposition," Burton says. Any articles, chapters, or other written documents all become discoverable documents that could ultimately harm the EP's own defense tactics and strategy.

• Upon identifying an expert plaintiff witness, it can be helpful to explore the background and credentials of the expert.

"Exploring the type of clinical practice that the plaintiff expert has can be useful. One is generally looking for mismatches relevant to the defense case," Burton says.

Experts who only work at large academic institutions can sometimes have their credibility questioned if the case involves care given at a small community ED, for instance.

If the expert is from an academic background, exploring the amount of clinical work that the individual has done in recent years to sustain their qualifications with regard to the statutes for the given state can be useful. "Most of this work will be expected of the defense team, and will not be an area where the defendant can become actively involved," Burton warns.

Zafren identifies these potential weaknesses in an expert's credibility, whether he or she is on the side of the plaintiff or the defendant: the expert is not in the same specialty as the defendant; the expert lacks board certification or has a lapsed board certification; the expert has not been active in the practice of medicine in several years.

An opposing expert occasionally offers opinions that are beyond the expert's area of knowledge. "The expert should help the attorney find an expert to refute these opinions," Zafren says. In some cases, the plaintiff's expert may rarely or never have seen the condition that led to the malpractice claim.

"This may be inevitable in cases involving rare conditions, but can still lead to questions about the witness's credibility," Zafren says. Another major weakness opposing experts on both sides can exploit is the situation in which an expert only testifies for plaintiffs or only testifies for defendants. "This can help the opposing attorney make the expert out to be a 'hired gun,'" Zafren says.

A plaintiff's expert, who testifies at trial before the defendant's experts, may convince the jury to believe his or her opinions. "This prejudices the jury against any contrary opinions offered by the defendant's expert," Zafren says. "To prevent this, the defendant's attorney will need to attack the credibility of the plaintiff's expert on cross-examination."

Zafren has testified in trials in which the opposing expert offered opinions that were clearly beyond his or her areas of expertise. One of Zafren's areas of expertise is cold injury. "Many opposing experts, although otherwise well-qualified in their own specialties, have offered opinions that showed ignorance of the most basic facts regarding cold injuries," he says. "I have instructed the attorney how to make this clear to the judge or jury." The attorney can use objections during cross-examination of an expert in an

effort to strike testimony beyond the expert's areas of expertise, or at least to decrease the weight of the testimony.

The defense expert witness will need to overcome similar efforts by the opposing attorney. At a recent deposition, a plaintiff's attorney attempted to disqualify Zafren as an expert by taking a published quote out of context, in an attempt to imply that he was biased in favor of defendants. "I was easily able to counter this line of attack," he says. "The judge will likely find that the quote was hearsay evidence and not admissible."

At the same deposition, the plaintiff's attorney challenged Zafren by citing the incorrect diagnosis of the treating physicians other than the defendant, as well as literature that the attorney alleged supported the plaintiff's position. "My counter to the claim that I disagreed with all the other doctors, including the author of an article that is clearly wrong, was that I reviewed the case and came to my own conclusion," Zafren says. ■

SOURCES

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Should EP Defendant Reject Malpractice Attorney Assigned By Carrier?

If an emergency physician (EP) defendant isn't happy with the attorney assigned by the insurance carrier, he or she can generally request another attorney, but is this a good idea?

"While malpractice carriers often have an attorney in mind for the case, they often utilize multiple defense firms in larger cities," says **Nathaniel Schlicher**, MD, JD, FACEP, associate director at TeamHealth Patient Safety Organization and attorney of counsel in the Seattle office of Johnson, Graffe, Keay, Moniz & Wick. The carrier will likely be flexible as to who will handle the EP's case.

"That said, when the carrier recommends a group of attorneys who have experience and a proven track record in medical malpractice defense, heed that advice carefully," Schlicher says.

The nuances of trial and of medical malpractice defense vary by state, he explains. The EP needs an attorney with the expertise to defend him or her to the fullest extent of the law. Factors that Schlicher would look for in an attorney include experience, past trial work, and the ability to handle the case in terms of time and resources. Also, the attorney should be a good match with the EP in terms of style and approach. "In the end, this is someone whom, despite your desire not to, you will spend a large chunk of the next one or two years working with," Schlicher says. "You need to get along and have an ability to communicate effectively."

Nan Gallagher, JD, Esq., a trial attorney with the law firm of Kern Augustine Conroy & Schoppmann in Bridgewater, NJ, says EPs should first conduct a telephone or face-to-face interview with their assigned malpractice counsel. "Make note of the attorney's ability to effectively articulate key issues in both law and medicine. After all, he or she is going to have to present your matter to a jury full of regular Joes and Janes," Gallagher says.

EPs should allow some time to pass and some developments to occur during the representation before deciding that completely new counsel is warranted. "Let the process play out," Gallagher advises. "Most liability insurance carriers are assiduous about only having seasoned and accomplished attorneys defend their insureds at the time of trial." Here are some factors to consider:

• What is the attorney's level of expertise?

"Even within the field of malpractice law, some attorneys are more experienced in emergency medicine cases versus other specialties," says **Jon Mark Hirshon**, MD, PhD, MPH, FACEP, associate professor in the Department of Emergency Medicine and an attending EP at the University of Maryland Medical Center in Baltimore..

• Is the attorney experienced in the particular jurisdiction?

"I live in an area where the malpractice environment is not the best. Attorneys may recommend that cases be settled here, that they would not settle someplace else," Hirshon says. The particular jurisdiction can become important when decisions need to be made whether to settle or defend a malpractice claim. "I, as a provider, would be very upset if I had to settle something that I thought was defensible. But maybe a lawyer can convince me that it's not defensible in

the jurisdiction," Hirshon says.

• What is the attorney's overall approach?

Stephen A. Barnes, MD, JD, FACLM, a trial attorney at McGehee Chang Barnes & Landgraf in Houston, recommends that the EP interview the attorneys on his malpractice carrier's list, and request the one that promotes honesty, fairness, and timeliness in getting facts to the plaintiff. "Delay does nothing but harm the emergency physician," he says. "Indeed, studies by insurance carriers themselves have shown that quick resolution of a bad outcome costs far less than dragging things out."

Barnes has found that common legal tactics that hide or delay the truth infuriate plaintiffs — often to the EP's detriment. "I am astonished by the level of deception, obfuscation, and delay that defendant doctors allow from their attorneys," he says. "Such maneuvers often further increase emotions of an injured plaintiff."

An infuriated plaintiff is likely to place blame on the EP instead of the defense attorney. "Understandably, a patient who sees that a lawsuit is being dragged out or that the defendant doctor is being coached by an attorney to hide the truth, leads to a decreased desire to resolve the dispute short of an actual trial," Barnes says.

This goes beyond the care provided by the defendant EP. "It includes recanting negative remarks the defendant made to the patient about another physician or hospital staff — or even worse, proactively covering up for others by stating that the standard of care was followed by others when the defendant knows in his or her heart that this is not true," Barnes says.

In Barnes' experience, defense attorneys who band together to present a common front often do so to the detriment of a single defendant. "If you stay on board that ship, you may well go down with it," he says, noting the plaintiff may refuse to accept a settlement offer. "A jury verdict against a physician causes far greater damage — including potential exposure to medical board actions — than a settlement," Barnes says. "A cooperative and honest defendant may even obtain a voluntary dismissal by the patient."

• What is the potential for conflict of interest if the EP wishes to settle the claim?

A defense attorney appointed by an insurance carrier must protect both the carrier's money and the physician's professional exposure. "But what if an insurance carrier wants to gamble on going to trial, risking the physician's professional reputation, ability to obtain privileges in the future, or medical board actions, should a jury find against the physician?" Barnes asks.

If the EP believes that a defense attorney from the insurance carrier won't follow the EP's instructions regarding managing the EP's own case, the EP may want to hire his or her own attorney. EPs may be reluctant to do this because of the expense involved. "But the reality is, the insurer-appointed defense attorney is paid by the insurer as the insurer's repeat player," Barnes says, adding that while the EP does not have to hire a personal attorney upfront, the EP can do so if and when the EP feels that their interests are becoming secondary to the insurer's.

If the EP wants to settle a case and move on, yet the insurance carrier wants to go to trial against the physician's wishes, Barnes adds, "the insurance carrier will prevail — unless the physician is aggressively proactive in his case and protects his own interests." ■

SOURCES

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This Documentation Can Strengthen the Defense of ED Wound Care Claims

Despite the routine nature of wound care in emergency departments (EDs), "many wounds are initially managed inappropriately, and can result in significant complications and mortality," warns **Gillian Schmitz**, MD, FACEP, associate program director in the Department of Emergency Medicine at University of Texas Health Science Center in San Antonio.

Up to 20% of all malpractice claims involving ED care and up to 11% of malpractice dollars paid out by emergency physicians (EPs) are related to wound care, she notes.

"There is tendency to think that

wounds aren't a big deal compared to heart attacks. But it's worth spending an extra minute of time to perform a complete exam and document it," Schmitz emphasizes. Retained foreign bodies and missed vascular injury are the most common allegations Schmitz sees in claims against EPs involving wound care. She offers these risk-reducing practices:

• Avoid saying, "Your X-ray looks fine. You can go home."

"Plain radiology has traditionally been the screening method of choice for retained foreign bodies, but a number of things can be missed on a routine film," Schmitz says. EPs might instead tell patients, "We don't see anything at this time, but the X-ray is a limited study. If symptoms continue or pain worsens, you need to come back and get the wound re-evaluated."

"EPs tend to forget X-rays are not going to pick up a fair amount of objects, or even fractures that don't show up initially," Schmitz says.

Sensitivity of ultrasound is largely based on the amount of training the EP has had, she adds. Even CT scans have limitations. "If a wood object is left in place for more than 48 hours, it absorbs water and has a density similar to soft tissue and can be missed," Schmitz says.

• Don't tell patients that there isn't a foreign body in the wound.

Instead, the EP might state, "I don't see anything at this time, but that doesn't mean that there isn't a small fragment hidden in there," and that patients should come back and have the wound re-evaluated if the wound appears infected. "Manage the patient's expectations," says Schmitz. A malpractice claim is more defensible if the ED chart indicates the EP explored and irrigated the wound and didn't see anything, and that the EP advised the patient of the risk that a foreign body may still be present.

• Explore the wound through the entire range of motion, and document this.

"Tendon injuries can be subtle," Schmitz says. "Unless you flex the hand, you are going to miss the injury to the tendon underneath." If the EP documents that the patient appeared to have intact motor sensation, says Schmitz, "you may still miss something, but at least you've thought about it and documented it."

Schmitz often sees ED charts that document the wound's size and location, and contain procedure notes of the laceration repair, but are missing any documentation of the neurovascular status. "If it later turns out to be an injury to a tendon or vessel underneath, it's hard to prove that you didn't miss it," says Schmitz.

• Consider calling in the wound care team.

EPs who don't hesitate to call in cardiology or neurology consultants when appropriate might not think of calling in the wound care team for challenging cases. "They may get a consult for everything else, but for whatever reason, that seems to be the piece that doesn't happen in the ED," **Joan Cerniglia-Lowensen**, JD, an attorney at Pessin Katz Law in Towson, MD, says.

If a total body inspection isn't completed in the ED and the patient later has a bad outcome, she warns, "the conclusion is going to be that either it was not present at admission, or it worsened as a result of bad care. I have seen this to be a very large pitfall for emergency physicians."

EPs tend to "gloss over" the total body assessment in the ED, says Cerniglia-Lowensen. "Just as we talk about heart failure and lung failure, this is skin failure. It's an important part of the general assessment," she says. If hospital or nursing staff are sued because of failure to present skin breakdown, the EP can also be named in the suit because "when you look backwards, the patient came in in the same condition," Cerniglia-Lowensen says. "It is a general risk management issue for the entire institution." ■

SOURCES

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CNE/CME QUESTIONS

1. Which is true regarding recently passed legislation involving federal quality metrics and reimbursement guidelines?

A. Federal healthcare metrics and reimbursement guidelines can be used to prove allegations of medical negligence.
B. Plaintiff attorneys may not assert a negligence claim against a doctor on the sole basis that he or she was penalized under any federal health care guideline or standard.
C. The fact that an emergency physician did not render a service covered under the Affordable Care Act can be used to assert that a physician breached his or her duty of care to a patient.
D. Plaintiff attorneys in a state case cannot bring up the facts related to an emergency physician's failure to meet a federal quality standard.

2. Which is recommended regarding emergency department policies, according to Robert J. Milligan, JD?

A. The EP should not document the reason for failing to follow the policy, as it may be used against the EP.
B. If the EP has a reason for not following the ED policy, he or she should document that reasoning.
C. Internally developed ED policies should be referred to as "standards."
D. ED policies should specify timeframes as imperatives.

3. Which is true regarding abnormal vital signs, according to John Davenport, MD?

A. Claims against emergency physicians are more defensible if the EP does not acknowledge the abnormal vitals at all in the chart.
B. EPs need not document diagnoses that the abnormal vital signs caused them to consider.
C. Rechecking abnormal vital signs complicates the EP's defense.
D. ED documentation should show that the abnormal signs were evaluated in the context of the individual patient.

4. Which is true regarding opposing expert witnesses, according to John Burton, MD?

A. Relevant literature presented by EP defendants to defense attorneys is not discoverable.
B. Journal articles produced by the defendant physician may ultimately become damaging to the strategy and positions taken to defend the case.
C. EP defendants need not review the deposition given by the plaintiff's expert, since the EP's attorney will do so.
D. The type of institution an expert witness practices in does not affect his or her credibility