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Don't Risk Defamation Suit From Lying "Expert"

Consult attorney and professional organizations

An expert witness for the plaintiff takes the stand and proceeds to tell the jury patently false statements regarding the standard of care. While this problem is certainly not unique to emergency medicine, it is "exacerbated by the number of 'experts' allowed by judges to testify based on limited exposure to emergency medicine, who are not themselves emergency physicians," says **Hugh F. Hill III**, MD, JD, FACEP, an assistant professor in the School of Medicine at Johns Hopkins University in Baltimore, MD.

In some cases, witnesses have no experience in the emergency department, except for a rotation while in training, adds Hill. "We have been a specialty for a generation, but have not yet completely shaken the perception that any physician can practice emergency medicine," he says.

Misleading testimony may also come from specialists in a particular disease or injury, such as a cardiologist testifying in a lawsuit involving the emergency care of a heart attack. "The cardiologist might be qualified to address the causation element of the plaintiff's case, but may also be used to comment on the standard of care, if the court permits, which it clearly should not," says Hill.

In one case, an emergency physician attempted to prevent a hyperbaric/critical care specialist from testifying against him in a carbon monoxide poisoning case.[1] Despite a state tort reform law from 2004 requiring standard of care experts be from the same specialty, the court allowed the expert, saying the specialty issue might affect credibility, but not competence to testify, says Hill.

Countersuit Inadvisable

In cases where the factual basis of the opinion or other factual assertions are either in error or outright misstatements, "such information in deposition can be researched before trial and challenged there," Hill says. "In trial itself, the defense has to know the statement to be false and be able to counter it."

Either way, the time for naming witnesses may have passed and, thus, the best — or perhaps the only — means of showing the falseness of the expert's assertions is blocked, says Hill.

"In one of my cases, the witness' claim that a procedure was 'always' done a certain way in his hospital was easily refuted by a call to nursing in that facility," says Hill. "But it was too late to even obtain an affidavit, much less a counter-witness."

Hill says that while looking up publications by the expert and finding statements helpful to the defense is part of the physician defendant's job, the defendant should not risk communicating with the expert directly, or with those who might influence the expert, such as his colleagues.

Investigation of the witness and the accuracy of his or her testimony has to be handled by the legal team, he stresses.

"For a physician to be on the receiving end of a lawsuit is a life-changing experience. They take this very personally, and often ask, 'Can I countersue?'" says **Rade Vukmir**, MD, JD, FACEP, FACHE, chairman of education and risk management at Traverse City, MI-based ECI Healthcare Partners and clinical professor of emergency medicine at Temple University in Philadelphia. "The answer is, 'Yes, you can. But it is often costly, and you would seldom prevail.'"

Tread Carefully

Physician defendants may be tempted to publish the testimony they believe deviates from evidence-based standards themselves in an attempt to discredit the expert. "Some people will post it on a blog, and they stand a risk of a defamation suit," says Vukmir.

Vukmir says that instead, the physician defendant should consult with an emergency medicine professional organization, such as the American College of Emergency Physicians (ACEP), to determine if the testimony truly deviates from established, evidence-based standards.

"You get the benefit of another group of knowledgeable people acting as a second unbiased filter before you do anything in the public realm," he says. "If that group looks at the testimony and thinks that it could go either way, that's typically where things need to stop. But if they think you have a point, then you can decide with them if any additional actions would make sense."

In some cases, both professional and commercial organizations have posted an expert's deposition and made it publicly searchable to their members, Vukmir says. What physician defendants should not do, he warns, is "to have a public discussion about the event. You should not reach out and contact people, write a letter to anyone involved, or start an electronic discussion about the case."

Even though it may appear to the physician defendant that the expert testified falsely, and he or she may have testified hundreds of times before, "they've done it within the broadly designed legal standards that have been created," says Vukmir.

"Discussion of protected medical-legal matters in the public forum will clearly not serve the physician's interests," he underscores. "The majority of physicians do the best that they can to take great care of patients with the resources that they have available. If they stick by that principle, that resonates with fact-finders far more than threats of an expert witness countersuit." **(See related story, p. 87, on the possibility of a sanctioned expert countersuing an organization.)** ■

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Disciplined Expert May Countersue

Sanctions may be inadmissible

The fact that an expert witness recently prevailed after suing a specialty society for suspending him for allegedly giving improper testimony in a medical negligence case won't affect the ability of the American College of Emergency Physicians (ACEP) to discipline unethical expert witnesses, according to **Louise B. Andrew**, MD, litigation stress counselor, founder and principal of www.MDMentor.com, and former chair of ACEP's Professional Liability Task Force Expert Witness subcommittee.

"However, if ACEP is sued by an expert who has been disciplined, it could affect ACEP's willingness to continue this program," she says. "The number of experts disciplined so far has been quite small, and the sanctions were fairly mild."

However, Andrew says that the verdict could encourage more expert witnesses to sue specialty societies that sanction their behavior.

Unaware of Options

"We know from a recent all-ACEP survey that EPs are extremely concerned about the problem of unethical testimony," Andrew reports. "And when they are affected by it, they sometimes react too quickly — and without regard to their own legal safety."

Although nearly 60% of more than 2,200 ACEP members surveyed in June and July 2010 reported having experienced litigation stress, 87% had not sought any assistance for dealing with it. More than a third of those who had sought assistance did so from colleagues.

The overwhelming majority of respondents were unaware of ACEP resources such as the peer-to-peer counseling mechanism. Although nearly 71% of respondents thought that ACEP should increase its current activities in regard to expert witness testimony, more than half were unaware of ACEP's expert witness and ethics policies and how to utilize them.

The survey was very lengthy and took at least 25 minutes to complete, yet many physicians took additional time to write in responses, most of which concerned litigation stress and expert witness issues. "The 10% response rate was almost unheard of with ACEP surveys. There was passion regarding these issues," Andrew says.

Is It Admissible?

"There have been attempts [to sanction expert witnesses], but few successes. Counter claims for restraint of trade can make the effort expensive for the organization," says Hill.

Given the infrequency of completed sanctions, subsequent use of them to attack the witness is not well-tested, he explains. "One would think it would be permitted in *voir dire*, and it would go to the credibility of the testimony in any subsequent case," he says.

When the defense is asking the witness questions in an attempt to show that he or she is not sufficiently well-versed in the subject to be able to state an opinion, the defense may ask about the fact that the expert was disciplined by a medical society, and use this to argue that the witness should not be allowed to testify, says Hill.

"If this is the only expert witness offered by the plaintiff as to standard of care, and the case is not susceptible to a *res ipsa loquitur* argument, it's all over," he says. "Of course, the plaintiff is unlikely to offer a witness known to be this vulnerable." ■

Inconsistently Available Specialty Services in ED?

Clinical disasters may result

If an ED claims to have certain services available, that creates a duty to provide them, according to **Douglas S. Diekema**, MD, MPH, an attending physician in the ED at Seattle Children's Hospital and director of education for the Treuman Katz Center for Pediatric Bioethics at Seattle (WA) Children's Research Institute.

If an ED claims to offer a service, and someone comes seeking that service or is brought there by an ambulance in the belief that the service is available, and the ED does not provide the service and the patient comes to any harm, "there would be significant risk of legal liability," says Diekema. "At a minimum, they would be at risk of a tort claim, should the patient choose to pursue one."

The ED might also be at risk of violating state or federal laws, including the Emergency Treatment and Active Labor Act (EMTALA), says Diekema.

A successful lawsuit requires finding that the hospital had a duty, failed to carry out that duty, and the patient came to harm as a result, notes Diekema. "One could argue that a hospital that has the capacity to offer a service, leads the community to believe that they offer the service, and then fails to offer the service at certain times, has failed to carry out its duty to the patient," he says.

Diekema says that these situations may put the hospital at more risk than the provider, adding that if the provider is on-call and expected to be on duty, the provider would be at risk.

"However, it would be unreasonable to hold a single provider to the duty to always be available," he says. "Rather, the hospital has the duty to assure that they have sufficient coverage to offer the service during those hours that are necessary to safeguard the welfare of their patients."

Services Unavailable

Hospitals may claim their emergency departments have expertise in specialty areas, only to fall far short of their promises, warns **Andrew Garlisi**, MD, MPH, MBA, VAQSF, medical director for Geauga County Emergency Medical Services (EMS) in Chardon, OH, allowing a plaintiff's attorney to successfully argue that these services weren't available when the patient presented to the ED.

Garlisi gives the example of a community hospital that claims to be a specialty center for treatment of sepsis. Although the hospital has an intensive care unit (ICU), and an intensivist is available onsite during certain daytime hours most days, the intensivist is not available after 5 p.m. or on weekends or holidays.

If a patient with severe sepsis is admitted from the ED to the ICU on Saturday evening, he or she may experience a steady decline in status through the night while a non-hospitalist staff internist awaits consultations from the infectious disease specialist and intensivist.

"The patient's pulmonary status may deteriorate until a 'rapid response' is finally called, at which point, the on-site anesthesiologist intubates the patient and provides initial ventilator orders," says Garlisi.

By the time the patient is actually seen by the admitting internist the following morning, he or she might not survive due to further clinical deterioration, with elevated troponin levels, worsening metabolic acidosis, and increased lethargy.

"The patient never had the benefit of intensivist, infectious disease, pulmonary, or cardiology consultations — even though timely consultations from such specialists would be expected from a hospital claiming to have expertise in the management of sepsis," says Garlisi.

In another example, a community hospital might look to increase its ED volume by advertising itself as a level III trauma center, marketing itself to local EMS providers, and hiring a trauma coordinator.

In addition, Garlisi says, the hospital creates a policy and procedures guideline for trauma management, which clearly states that the on-call trauma surgeon will respond in person to the ED to the Trauma Alert page, which is defined by mechanism of injury and presenting signs and symptoms.

If a trauma patient arrives at the ED with signs of significant abdominal trauma, the EP may anticipate arrival of the trauma surgeon instead of transferring the patient to the level I trauma center, and begin a diagnostic evaluation including CT scans of the head, neck, chest, abdomen, and pelvis.

If there are significant delays in receiving CT interpretations due to the high volume of activity via teleradiology, and the trauma surgeon never presents to the ED because the patient's vital signs were initially normal, the patient's condition may

suddenly deteriorate before he or she is finally transferred to the level I trauma center.

The delay in definitive care could possibly cost the patient his life, says Garlisi. "Bending to the pressure to maintain financial viability in a highly competitive health care market, some community hospitals overextend themselves," he says. "They advertise services which they cannot consistently provide with high quality."

To attract patients, EDs are marketing themselves as chest pain centers, stroke centers, trauma centers, geriatric centers, sepsis centers, and pediatric centers, explains Garlisi.

"If the facility has the capability and capacity to perform these services consistently — on weekends, holidays, and after 5 p.m. — no problem," he says. "If the hospital can only perform any or all these services marginally and inconsistently, then someone will suffer and a price will be paid." ■

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Unavailable Specialist = Legal Woes for EPs

In one case that was eventually settled, an on-call specialist admitted making no effort to come in promptly, stating that traffic would be untenable for an hour because it was near the end of a Chicago Bulls playoff, recalls **Tom Scaletta**, MD, FAAEM, chair of the ED at Edward Hospital in Naperville, IL, and the emergency physician (EP) quoted the specialist verbatim to make it clear why a transfer was initiated.

"In such cases, it is important for the EP to document factually and unemotionally the efforts he or she made in order to do what was best for the patient, given resource limitations," he says.

In addition, the EP must exhaust all possibilities, such as calling another specialist on staff that is not on-call, says Scaletta. "The chief-of-staff and supervising department chair should be notified and asked to intervene," he says. "As well, the on-duty administrator or hospital attorney should be alerted while such situations are unfolding."

Explain Delays

The Emergency Medical Treatment and Labor Act (EMTALA) and medical staff bylaws dictate how on-call obligations are managed, says Scaletta. "If a call schedule is posted for a particular specialty, there better be a great reason an external transfer within the scope of that doctor's expertise was initiated," he says.

However, Scaletta says it is understandable that certain specialists are available on an occasional basis. For instance, if there is only one neurosurgeon on staff, then it is permissible to have many holes in the schedule, and EMTALA permits the on-call neurosurgeon to be on call at more than one hospital.

"If a patient arrives and the physician is operating across town, it is reasonable for the patient to be transferred either to where the neurosurgeon is operating or to a tertiary center, whichever is best for the patient," says Scaletta. "Defense in malpractice suits may be strengthened by EMTALA compliance and unwinnable by EMTALA ignorance."

Hospital services, too, are subject to reasonable levels of availability. "If a hospital has limited hours of operation for a certain technology, that ought to be spelled out in the marketing fine print," Scaletta says. "Delays in treatment for a time-sensitive problem, which result in damages, need to be rationally explained."

It is understandable, for example, that time to percutaneous coronary intervention lengthens after hours or on weekends because the catheterization lab staff generally need to be called in.

Centers of excellence may be better able to convince a jury that negative outcomes are sometimes unpreventable and do not necessarily equate to malpractice, says Scaletta.

"Still, when a standard of care is clearly unmet in a center that claims to be better than most, juries are not sympathetic," adds Scaletta. "And even if a hospital is not a center of excellence in a

particular area, no plaintiff accepts substandard care."

Pull "Documentation Trigger"

Andrew Lawson, MD, FACEP, CPCC, acting director of quality assurance and quality improvement for the emergency physician group at Mission Hospital Regional Medical Center and principal of Lawson Coaching and Consulting, both in Southern California, says the EP should tell the consultant, "I am concerned for this patient. I am asking for your help. Can you please come in right away?"

If the consultant still refuses to come to the ED, Lawson says "it all comes down to documentation. It's important to be clear about what you actually said to them," he says. "Ask them what time you can expect them, so that can be documented."

Lawson says, however, that EPs should "pull that documentation trigger carefully — when you have a really sick patient or a critical situation. And I think it is only fair to tell the specialist what you are documenting."

The EP should document, for instance, "I was concerned for this patient. I asked the surgeon to come in immediately," and specify what he or she is concerned about. Lawson says that when reviewing charts, he sees this type of documentation only very rarely.

While contemporaneous documentation is protective legally for the EP, the plaintiff attorney "may still find a loophole to keep them in," says Lawson. "If the patient is sitting right next to you, then you will be hit a lot harder than a physician outside the ER who can claim that he wasn't told of all the findings." ■

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ED Attending: Liable for Bad Outcome, or Not?

Can the ED attending physician be held liable for a patient's bad outcome even if he or she never saw the patient? In almost all cases, the answer is "yes," at least to some degree, according to **Kevin Klauer**, DO, EJD, chief medical officer for Emergency Medicine Physicians in Canton, OH, and a member of the board of directors at Physicians Specialty Limited Risk Retention Group.

"The ED attending is responsible for *all* the patients in the ED, to one degree or another, especially if there is single coverage and you are the only physician there," he says. "To say you are not responsible for any one of them just because you didn't see them is unreasonable."

Misconceptions about who is responsible "can lead to embarrassing and serious problems for ED physicians," says **Robert J. Conroy**, JD, an attorney at Kern, Augustine, Conroy, & Schoppmann in Bridgewater, NJ. "Not only medical liability problems, but professional discipline issues can arise from these types of incidents."

Liability for Residents

Months after a patient with a pneumothorax required a blood transfusion due to being given a blood thinner by a resident for suspected pulmonary embolism, **Douglas Wheaton**, MD, an attending physician in the ED at St. John Hospital and Medical Center in Detroit, MI, found himself involved in the hospital's internal investigation of the case, even though he'd never seen the patient.

An ED nurse documenting in the EMR needed to enter an attending physician's name for a chest X-ray that was ordered, and Wheaton was on duty in the ED at that point in time. "I found myself getting blamed for a complication for something that I never did, or would do," he says. "They found that as the attending physician over the resident, it should have been my responsibility to go back and make sure everything was done correctly. If you're there on duty, it's your problem — even if you don't know there is a problem."

If the resident is a licensed physician, however, whether he or she is supervised by a chief resident or an attending, then that resident will probably end up standing alone if a lawsuit occurs, Klauer adds.

"Liability is probably not going to extend up to providers whose signatures and names are not on the chart, who haven't established a physician-patient relationship," he says.

Risks with Midlevels

Even if the ED's guidelines state that midlevel providers can function autonomously and without direct supervision, the plaintiff's attorney can still ask, "Who was in charge of the ED at the time?"

"If it was you, and they know that you could have taken a walk down that hallway to see that patient, and either by your policy or your choice you didn't do so, there is nothing to stop them from naming you in a lawsuit," says Klauer.

ED attendings should *not* assume that that they are insulated from liability just because they didn't independently evaluate a patient seen by a midlevel provider, says Klauer. "This is a misconception, resulting in a false sense of confidence," he adds.

Klauer says that in his experience, plaintiff attorneys typically name all potential defendants, including the EP and potentially individuals who signed a supervisory agreement for the physician's assistant (PA) to work in the department. "We've occasionally had situations where the physician has gotten out of a case on a motion for summary judgment where the PA provided the care, and the EP signed the chart but never saw the patient," reports **Martin Ogle**, MD, FACEP, vice president of CEP America, an Emeryville, CA-based provider of emergency department management and staffing solutions. "But that is happening less and less."

ED policies stating that midlevel providers see certain patients without direct supervision "insulate you a bit," according to Klauer. "But nonetheless, we run the ED. The attending physician is the captain of the ship," he says. "You can't claim authority and then abdicate your culpability later and say, 'I'm in charge except for certain cases.'"

Bad Outcomes in Boarders

Wheaton says that with admitted ED patients, "the cases that aren't immediately life-threatening but could become so, are the ones that are going to bite you." These include septic patients and cardiac cases without acute changes on the EKG with an unrecognized ischemic process underway.

St. John Hospital and Medical Center's ED implemented a process where admitted patients leave the ED as soon as the nurse gives the report, with other admitting services contacted if the admitting physician doesn't call back quickly enough. "As soon as we can get the patient out of the ED, we do," Wheaton says.

Even if an adverse outcome occurs well *after* the patient leaves the ED, however, the EP is still potentially liable, stresses Wheaton.

"Often, something bad happens right after the patient goes up to the floor, or within a period of time they are coding the person," he says. "If there was an error made in the ED — something you did or something you didn't do — liability is going to carry over."

The ED attending also could be liable if he or she is the only physician available and fails to respond to a code if the admitted patient arrests after leaving the ED and being admitted to the floor, says Conroy.

"Similarly, where the ED attending knows, or should know, that the admitting physician may be delayed in arriving at the bedside, and there are matters that need to be followed-up immediately, the ED attending might also be liable," he says. Here are strategies to reduce legal risks for attending physicians involving admitted patients held in the ED:

EPs should generally not write admission orders beyond a holding order.

"There is not a lot of case law on this, but there is certainly a lot of liability and exposure here," says Klauer. "If you go beyond 'Admit to Doctor X on telemetry, call upon arrival,' and start writing orders for diet, medications, vital signs, and everything else, you have allowed the admitting physician to do something else instead of come and take care of their patient."

By writing additional orders, explains Klauer, the EP has in essence assumed care of the patient on the floor with no intention of following the patient's care after he or she leaves the ED.

"If something bad happens before that attending either calls in and gives orders or comes to see the patient, you are the only physician of record at that point involved in this patient's care," he says. "That puts you at great risk."

Klauer says that writing a whole list of admission orders is not in the EP's nor the patient's best interest, as the EP is not planning on following-up on those orders, and is not actively managing the patient.

Instead, Klauer recommends writing a bridging order to "call for orders upon arrival," with only the essential pieces of information needed to secure the bed — the diagnosis, the name of the physician admitting the patient, and what floor the patient is going to.

"As soon as they call for orders, you are no longer taking care of them. That is a clear transmission of responsibility," he says, adding that ED nurses can take the orders, or the admitting physician can submit them into the EMR onsite or offsite.

EPs should be aware of requirements in hospital bylaws.

"There is no bright line between when our liability ends and when the admitting physician's liability begins," says Ogle. "It's very much a gray area."

The EP's making a specific declaration in the medical record that care has been transferred to the admitting physician may help, Klauer says, but there is no guarantee that even this documentation will serve as protection from a lawsuit.

Hospital bylaws may require that a patient admitted from the ED be seen by the admitting physician within a specific timeframe, such as an hour or two if they are going to the intensive care unit (ICU), but the EP can still be named in the lawsuit even if the admitting physician *doesn't* comply with this requirement, says Klauer.

"If the other physician didn't see the patient, that can help the EP. But all it is going to do is add an additional defendant," he says.

If the EP is the only one managing the patient's care based on the orders written, and the patient stays in the ED waiting for the admitting physician to get to the beside, "something bad could happen and you were the last person to care for them. It puts you in a bad position," explains Klauer.

The transition of care from ED attending to admitting physician must be clearly defined.

"You need a clear demarcation for where the outpatient management in the ED stops and the inpatient management begins," says Klauer.

Catherine Ballard, JD, a partner and vice-chair of the Bricker & Eckler Health Care group in Columbus, OH, says that the point at which responsibility shifts from the EP to the admitting physician should be clearly set out in the hospital's rules and regulations.

If EPs fail to follow the hospital's policies and guidelines regarding this scenario, "you find yourself in a situation where you defined a standard of care based on your policies and rules, and you are not following it," says Ogle. "That is a hard thing to overcome."

Since the EP remains liable for the patient until there is a transfer of the patient to the admitting physician, says Ballard, there is a need for rules to define this process, including transfer orders and awareness of nursing staff of the patient's arrival.

"There should be no gaps in coverage," says Ballard. "To the extent gaps do exist, there is a potential that the EP, the admitting physician, and the hospital will *all* be held responsible for harm that the patient suffers as a result of the gap."

If a bad outcome occurs and the patient sues, Klauer says one of the plaintiff attorney's first questions is going to be, "Who was the physician in closest proximity in the ED?"

"It was the EP, and you are still going to have exposure. You can't insulate yourself from liability just because the patient is admitted," Klauer says. "If they are in the ED, they are an ED patient. That is the simplest rule to follow, and it will keep you out of trouble."

Admitting physicians should be involved in the patient's care as early as possible.

The EP's risks are somewhat lessened if the admitting physician is rounding on the patient and writing orders for the patient, says Klauer. "If the admitting physician is involved and actively engaged in the patient's care, it speaks to the transition of care," he explains.

Klauer acknowledges, however, that it's rare for the admitting physician to take active responsibility for the care of a patient being held in the ED, and even if they do, "the patient is still in the ED and there is still exposure for the EP."

Klauer cautions against avoiding appropriate interventions in the ED for admitted patients simply to claim non-involvement. "Doing less just so you can say 'I wasn't involved,' is not a defense," he says.

If a bad outcome occurs after the patient leaves the ED, the plaintiff's attorney will discover that the patient was starting to go in the wrong direction while in the ED, with no one managing their care, Klauer warns.

"I'm not saying you can manage every inpatient — you can't. ICU patients belong in the ICU, not the ED," says Klauer. "But to think you can mitigate that risk by saying 'I'm just not involved because they're not my patient' is not a defense. That is a failed strategy for sure." ■

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Hospital Boasts on ED Care Could Come Up During Suit

Attorneys monitoring advertisements

Your hospital's public relations staff may jump at the chance to advertise that patients can expect to see a doctor within 30 minutes in your ED, but claims such as this could easily backfire if a lawsuit involves this issue.

"Plaintiff attorneys will peruse web sites and print ads looking for information that can help them," says **Joseph P. McMenamin,** MD, JD, FCLM, a partner at Richmond, VA-based McGuireWoods and a former practicing emergency physician. "If you are thinking like a plaintiff's attorney, the most helpful evidence may be the words and images published by the hospital itself."

The plaintiff could make it appear that the ED was under administrative pressure to push patients through quickly, he says, and might then depose the ED medical director or others responsible for the effort to decrease length of stay.

"If the claim is that the patient got short shrift by the ED, and the physician didn't take the time to listen to the patient's history, that could be bolstered by the hospital's claim that it gets people through the system quickly," McMenamin says. "If there is an allegation that that was in some way negligently done, marketing statements such as these could be a way to get to the hospital."

Although marketing materials do not establish the standard of care for length of stay, says McMenamin, depending on state law, plaintiff's counsel may be able to argue that the ED effectively created its own standard or, perhaps less implausibly, created a contract that it breached by failing to behave as advertised.

"The jury may say, 'You guys said you were way better than the standard of care,'" says McMenamin. "There are lots of ED cases where clinicians clearly met the standard of care, but the jury says, 'We just don't like the outcome, and therefore, you lose.'" Here are other commonly advertised claims involving ED care that could make a case less defensible:

• The fact that EPs are board certified.

"There are several reasons why accuracy in advertising is important, but one is heightened professional liability exposure if inaccuracies are allowed to creep in," says McMenamin.

The ED may have a non-boarded moonlighter, or a physician who is board-eligible in emergency medicine but not certified, or a physician who was trained in a specialty other than emergency medicine, for instance. This could easily come up during litigation when the EP defendant submits a CV indicating he or she is not board certified in emergency medicine, when the hospital website clearly states the ED has board-certified EPs, McMenamin explains.

• Excellence in stroke care.

Patients may have much higher expectations after seeing a hospital's billboard stating, "Our ED is number one in the state for management of strokes."

"If someone goes there and doesn't get a great outcome, they will be disappointed, and may be more likely to initiate legal action against you," says **Alfred Sacchetti**, MD, FACEP, chief of emergency services at Our Lady of Lourdes Medical Center in Camden, NJ, and assistant clinical professor of emergency medicine at Thomas Jefferson University in Philadelphia, PA.

The plaintiff attorney might even argue that the

ED should be held to a higher standard of care, says McMenamin, adding that state law may or may not permit such an argument.

"A good plaintiff attorney can put it into the jury's mind that because the ED advertises how wonderful they are, they should be better than everybody else," Sacchetti says. "People will be able to twist this one way or the other."

If the ED advertises that it's the best in the state in managing pneumonia, for instance, the defense attorney could argue that in light of this, the patient's bad outcome would clearly have occurred in any ED. "But I think that type of braggart behavior would only backfire on you. The amount of hubris would turn a jury off," Sacchetti says. ■

Sources

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Late Entries to the EMR: Do They Help or Hurt Defense?

Attorneys will uncover "true story"

A plaintiff's attorney in a missed myocardial infarction case showed the jury an EMR entry indicating the patient's heart rate was within normal limits, as well as vital signs taken by a nurse's assistant showing severe tachycardia.

"The one careless 'checkbox' entry was used to absolutely gut the strength of pages and pages of good entries." says **D. Jay Davis, Jr.**, a partner at Young Clement Rivers in Charleston, SC, and chair of the firm's Medical Liability Practice Group, who successfully represented the EP defendant.

"The doctor did what he was supposed to do. But the plaintiff's lawyer argued to the jury that they cannot trust any of the findings in the EMR," he says. "Ultimately, I think the jury did not fault the doctor for the inconsistency. But it was a huge problem for the defense."

A late entry would have made the case easier to defend, he says, because it would have addressed the discrepancy that had been clearly noted in a different part of the record. "Changes to eliminate an inconsistency in charting can help with the validity of the 'good' entries that you are relying on in the record," says Davis.

Doubts Are Raised

The same rules apply for making late entries in a patient's medical record, whether it is paper or electronic, says **William C. Gerard**, MD, MMM, FACEP, chairman and professional director of emergency services at Palmetto Health Richland in Columbia, SC. "What is different is that every time the electronic chart is 'touched,' there is a time-date stamp and your access is recorded," he says. "No need to add a date and time; it speaks for itself. There is 100% transparency about when you added the addendum."

Late entries can cause the accuracy of the entire medical record to be questioned, says Gerard, "which the lawyer can then use to deconstruct the accurately documented timeline, and then extrapolate that to anything in the EMR altogether."

A plaintiff's lawyer may hire a computer forensic specialist to draw out the "true story" of the chart with technology by making the metadata available for viewing, says Davis, adding that an otherwise credible defense witness may have a difficult time answering questions about entries made after a bad outcome.

"If comments are changed, erased, or deleted and the computer specialist finds it, that will be shown to the jury," he warns. "After that point, the witness will have zero credibility." Here are risk-reducing strategies involving late EMR entries:

• Entries made after a bad outcome should be strictly factual.

"Leave subjective comments and statements out. They will be seen as self-serving at best and admissions of guilt at worst," says Davis. He adds that anything an EP actually did, but did not document at the time, is a reasonable addition to make after the fact — so long as it can be confirmed or verified independently.

For instance, an EP might note that he reviewed an EKG or lab result and the findings were normal or did not warrant follow-up based on the presentation that is in the chart. "This still must be noted as a late entry. But the 'evidence' is there, and objective in nature," says Davis.

EPs should not add criticisms of other providers or their decisions, stresses Davis, or explain why interventions or tests were not done after a bad outcome.

"This does no one any good, appears to acknowledge mistakes, and gives plaintiff's lawyers potential theories of liability they may never have thought of in the case," he says. Davis says making a late entry stating that a patient left against medical advice "is dangerous. Not only does it appear self-serving, but it potentially blames the patient, which can backfire in court."

• Late entries should be clearly noted as such.

EPs should not hesitate to complete the record with facts they recall, so long as the late entry is clearly noted as such, says Davis, but "be clear about the timing, be factual about the entry, and be honest."

• Late entries must not inadvertently give a false time line.

In some cases, EPs make late entries to the EMR to get something in the record that was concurrently documented in a paper chart. "The classic example is a cardiac arrest code situation," says Gerard. "Everything happens at a rapid pace and the ordering of therapy outpaces any chance for electronic entry, so it is documented on paper."

After the event, the orders are placed in the system electronically, but they now appear to be given after the event and are asynchronous to the paper version. "This is an incredible legal risk. Discrepancies in time in any critical event opens the door for liability," says Gerard.

If verbal orders are given by the EP during a traumatic code blue while the documenting nurse scribbles the orders and times on a sheet of paper, the EP may later go back to attribute the verbal orders to the doctors who were directing the code.

"He does not change the time of the orders to match the time scribbled down, and the paper is destroyed," says Gerard. "So when did the patient get the fluids and medications? Thirty minutes after he got there? No wonder he expired."

Gerard says that EDs should have a policy in place to explain this process, "and the orders must contain metadata that explains that they are being documented after the fact, including when they were administered, and not just when they were entered into the system." ■

Sources

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CNE/CME OBJECTIVES

After completing this activity, participants will be able to:

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

CNE/CME INSTRUCTIONS

HERE ARE THE STEPS YOU NEED TO TAKE TO EARN CREDIT FOR THIS ACTIVITY:

1. Read and study the activity, using the provided references for further research.

2. Log on to **www.cmecity.com** to take a post-test; tests can be taken after each issue or collectively at the end of the semester. *First-time users will have to register on the site using the 8-digit subscriber number printed on their mailing label, invoice, or renewal notice.*

3. Pass the online tests with a score of 100%; you will be allowed to answer the questions as many times as needed to achieve a score of 100%.

4. After successfully completing the last test of the semester, your browser will be automatically directed to the activity evaluation form, which you will submit online.

5. Once the evaluation is received, a credit letter will be sent to you. ■

CNE/CME QUESTIONS

1. Which of the following is recommended regarding late entries made to an ED's electronic medical record, according to **D. Jay Davis**, Jr.?
   A. It is reasonable for the EP to note that he or she reviewed a diagnostic test and the findings were normal or did not warrant follow-up based on the presentation that is in the chart.
   B. It is advisable for EPs to make late entries criticizing other providers or their decisions.
   C. EPs should add a detailed explanation for why interventions or tests were not done after a bad outcome occurs.
   D. A late entry stating that a patient left against medical advice will generally make a case more defensible.

2. Which is true regarding the ED attending physician's legal responsibility for patients, according to **Kevin Klauer**, MD?
   A. The ED attending is not legally responsible for care given by a midlevel provider unless he or she actually saw the patient.
   B. The ED attending is responsible for care given by midlevel providers unless the ED's guidelines state that midlevel providers can function autonomously and without direct supervision.
   C. ED attendings should assume they are legally responsible for the care given by midlevel providers, whether they saw the patient or simply signed off on a supervisory basis.
   D. If the ED attending is named in a lawsuit involving a bad outcome resulting from care provided by a physician's assistant under his or her supervision, the defense's motion for summary judgment will be granted and the EP will be dismissed from the case, as long as the EP signed the chart but never saw the patient.

3. Which is true regarding reducing risks of admitted patients being held in the ED, according to **Catherine Ballard**, JD?
   A. It is advisable for EPs to routinely write additional orders for admitted patients including diet, medications, and vital signs.
   B. Risks are increased if the EP writes only a bridging order with the essential pieces of information needed to secure the bed.
   C. The EP will not be named in a lawsuit, or will be dismissed from the case if named initially, as long as the documentation clearly shows that the admitting physician did not comply with timeframes specified in hospital bylaws for seeing the patient.
   D. The hospital's rules and regulations should clearly specify when responsibility shifts from the ED attending physician to the admitting physician.