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INSIDE

Physician Health and Malpractice Risk: A Look at *Holmes v. Lyons*

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The national focus on healthcare provider wellness is gaining traction. As an integral part of this process, the medical community has seen an increased openness in the discussion of personal experiences, such as in the article penned by Dr. Susan Haney in the December 2018 issue of *ACEP Now*.[1] Dr. Haney's story details how her self-disclosure to the state medical board regarding her personal health adversely affected her career.

When reflecting on the challenges of a state licensing board investigation (and the public nature of the board's determination), a question that often follows is: If licensing investigations and state board determinations are public information, how does this process affect medical malpractice actions? More broadly, regardless of whether there has been a formal board investigation, how do physician health issues/potential impairments factor into a medical malpractice case? One can look to *Holmes v. Lyons* to explore how one state has recently approached this question.[2]

In *Holmes*, Bonnie Holmes sued Thomas Lyons, MD, regarding complications of gynecologic surgery performed in 2015. After the surgery, which included a laparoscopic hysterectomy and lysis of adhesions, Ms. Holmes was diagnosed with a distal ureteral injury and developed uterovaginal fistulas. Initially, the case was dismissed at the trial level. Multiple claims were brought by the plaintiff, but for the purposes of this discussion, we will focus on the appellate court's disposition of the plaintiff's claims of fraud, battery, and negligent misrepresentation.

The Facts

In 2010, Dr. Lyons filed insurance claims with his disability carriers

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regarding what he believed was his impaired ability to continue to perform gynecologic surgery. When those claims were denied, he filed a civil suit against his insurers. Although the court opinion in *Holmes* does not state at what point the plaintiff became aware of this information (i.e., before or during her lawsuit), it is not disputed that it was not disclosed to her prior to the 2015 surgery at the crux of the case.

As part of Dr. Lyons' disability claim (presumably discovered by the plaintiff by the interrogatories related to her initial claim), he submitted a PT evaluation that stated, in part, his "functional capabilities do not match the physical demand requirements of his job" due to weakness affecting his ability to stand, vision problems affecting depth perception, and bilaterally diminished fine and gross motor function of the hands.

Dr. Lyons' explanation for his disability included orthopedic issues and that he had suffered a stroke in 2011. His insurance claim and its supporting paperwork were entered into evidence by the plaintiff in support of her malpractice claim as well as in support of her separate claims of fraud, battery, and negligent misrepresentation. This was an attempt to support her allegations that the defendant was, by his own admission, not capable of performing surgery.

Further, the plaintiff alleged that the defendant failed to obtain informed consent when the physician did not disclose his physical impairments that affected his ability to perform surgery. This raised a battery claim and an allegation that these impairments increased the plaintiff's risk and directly resulted in her injury.

These allegations were echoed by the plaintiff's expert medical opinion in support of her medical malpractice claim.

The Law

In Georgia, where the events giving rise to this suit occurred, state law proscribes that a physician's failure to disclose "negative life factors" that may adversely affect physician performance and/or ability to meet the standard of care is not a basis for claims *separate* from the malpractice action.[3] Previously, a court interpreted the law thusly: Because such factors were not included among the statutorily enumerated risks required to be disclosed, and because the statute must be interpreted on its face (i.e., by its plain language), physicians were not required to disclose personal factors that might affect their performance. Therefore, a failure to disclose could not be the basis of a separate cause of action.[4]

However, the Court of Appeals of Georgia took a new approach, distinguishing the current case from the prior interpretation. The appeals court applied the statute more broadly because here, the personal factors were directly related to the treatment (i.e., specific risks of surgery, such as ureteral injury). Therefore, the court ruled that the summary dismissal of plaintiff's separate claims must be overturned.

Points of Interest and Discussion

First, it is important to note that this is not a ruling on the merits of plaintiff's claims; instead, it simply reverses the summary disposition (i.e., dismissal) of the plaintiff's initial claims. Georgia has yet to rule on the merits. Second, the facts in

the case are unique in part because they pertain to the defendant's own admission of his disability and its direct impact on his ability to practice medicine and meet the standard of care in his chosen specialty. Third, state law varies; the interpretation here cannot be readily extrapolated to apply similarly in all states. However, considering this case speaks directly to one state's handling of physician health factors affecting a patient's civil suit, it is useful to examine.

How does this apply to licensing investigations and determinations reached by a state medical board? First, as is true of the civil suit filed by Dr. Lyons against his disability insurers, state medical board action is public information. Additionally, it is discoverable by the plaintiff in the normal course of a medical malpractice lawsuit. Thus, this information is likely to come into play during a malpractice action. Second, although a state board investigation may not as cleanly delineate how a provider's alleged disability directly affects specific aspects of care (particularly in a manner supported by a medical expert retained by the physician), it certainly will speak to the ability of the provider to practice and meet the standard of care. Thus, a similar application in malpractice litigation is likely. If a physician's health issue (including mental health and substance abuse) can be argued to directly affect the ability to practice and meet the standard of care, a plaintiff almost certainly will attempt to use it to support his or her claim.

What does this mean for providers? Is a physician required to share confidential medical information with patients to practice? Preliminarily, the most palatable answer lies in self-regulation. It seems reasonable to suggest that physicians are well-qualified to determine which health issues will affect practice substantially. A non-punitive, confidential mechanism to self-police (and allow colleagues to assist those providers without sufficient insight to do so) would be a significant step toward protecting patients and providers alike. Until such a framework is universally available, the answer becomes more complicated (and beyond the scope of this article). The burgeoning focus on provider wellness and resources is a step in the right direction.

Conclusion

Practically speaking, if a state board licensing investigation is initiated, it is wise to immediately consult an attorney who is familiar with applicable law. The provider's medical malpractice carrier may be an appropriate resource, depending on policy coverage. Regardless, inaction or unguided interaction with investigators may yield a damaging result, as was illustrated by Dr. Haney's description of her interaction with her state medical board. Cases like these are a challenging factor in the tension between physician wellness and the shift to a culture of openness about physician wellness and medicolegal risk. Thus, physician involvement in shaping how the states manage these issues has the potential to positively affect the health of both physicians and their patients. ■

REFERENCES

1. Haney ST. Emergency Physician with Depression Chronicles Her 10-Year Fight to Keep Her License. ACEP Now, Dec. 17, 2018. Available at: http://bit.ly/2Z0M6R4. Accessed June 4, 2019.
2. *Holmes et al v. Lyons et al*, A18A0277 (Court of Appeals of Georgia, June 1, 2018).
3. OCGA § 31-9-6.1(a).
4. *Albany Urology Clinic PC v. Cleveland*, S99G0600 (Supreme Court of Georgia, March 6, 2000).

Attorneys Use EMTALA in False Claims Act Lawsuits — So Far, Unsuccessfully

Recent dismissals could be a positive development for emergency physicians

Two recent lawsuits, both filed in Mississippi, tested a novel theory of liability. Attorneys argued that the hospital did not provide stabilizing treatment or transfer as required by the Emergency Medical Treatment and Labor Act (EMTALA), rendering patient bills to the federal government actionable under the False Claims Act (FCA).[1,2]

"The lawsuits argue that had the regulators known about the EMTALA violations, they would not have paid for the care," explains **Timothy C. Gutwald**, JD, a healthcare attorney in the Grand Rapids, MI, office of Miller Johnson.

The Department of Justice (DOJ) moved to dismiss the cases, both of which alleged FCA violations based on purported EMTALA violations.[3,4]

"These two FCA actions are good examples of the DOJ's use of its authority to dismiss cases that lack merit and could interfere with agency goals," says **Derek Adams**, JD, a partner at Feldesman Tucker Leifer Fidell in Washington, DC. In explaining its rationale, the DOJ wrote, *"EMTALA violations typically involve turning patients away from a hospital emergency room rather than treating them and, thus, do not lead to the submission of any false claims to the government."*

One case was dismissed in March 2019, and the other is pending. "The False Claims Act was never intended to address every potential regulatory violation," says **George B. Breen**, JD, adding that there are existing administrative remedies to address EMTALA violations. "The government apparently recognized this in taking the affirmative step to seek dismissal of these cases after it had declined to intervene in each of them," says Breen, an attorney at Washington DC-based Epstein Becker & Green.

Previously, the DOJ used its authority sparingly to dismiss FCA actions brought by whistleblowers. Even baseless cases were allowed to proceed. "This caused healthcare providers to spend considerable resources defending against meritless claims," Breen explains. The DOJ's forceful rejection of the allegations in the recent cases suggest this is no longer the status quo, making additional similar cases unlikely.

"We might see another attempt, but I think it is wasted effort and money for the attorney. Most will avoid this theory of liability in the future," says **Stephen A. Frew**, JD, vice president of risk consulting at Johnson Insurance Services and a Rockford, IL-based attorney.

It is equally unlikely a plaintiff attorney will use *qui tam* lawsuits (cases brought by a whistleblower who exposes fraud on the government) as a way to bolster malpractice cases, Gutwald says. "They are very complex and move much more slowly than your typical civil suit."

FCA Theory a Stretch

Depending on the court where the action is filed, it is always possible there could be a different outcome if other FCA cases are filed. "But, overall, I think this FCA theory is a stretch," says **Mary C. Malone**, JD, a partner at Hancock Daniel in Richmond, VA. Nonetheless, providers should continue to watch these lawsuits closely, Malone advises. "The *Escobar* decision really broadened the landscape for FCA claims in many respects."[5] Prior to that decision, FCA claims essentially were rooted in failure to meet certain conditions of payment, not Medicare Conditions of Participation. "But the post-*Escobar* standard makes it clear that failure to meet a Condition of Participation could create the basis for an FCA action — if that failure was material to the payment of claims by the government," Malone adds.

EMTALA is tied to the Medicare Conditions of Participation. This could create the basis for false claims liability. "However, to date, making EMTALA violations the basis for FCA claims is not very practical and ultimately may be proved not to meet the *Escobar* materiality standard," Malone says.

Currently, the government seems to prefer handling EMTALA violations through the administrative process and the associated penalties. "But if EMTALA ever did create the basis for FCA liability, the financial penalties could be much higher than current civil monetary penalties assigned for EMTALA violations," Malone cautions.

Refunding payments is one way to eliminate any potential liability under the FCA. "If ED providers identify an EMTALA violation, a very conservative approach would be to either not bill for the services provided during that encounter, or to issue a refund to the government for any payment," Gutwald says.

Whistleblowing in EDs

The primary cause of EMTALA citations is mandatory reporting by other hospitals that receive a patient who was improperly transferred under EMTALA. However, whistleblower cases do occur regularly, according to Frew.

EXECUTIVE SUMMARY

The Department of Justice moved to dismiss several recent False Claims Act lawsuits based on alleged EMTALA violations. Medical/legal experts interviewed by *ED Legal Letter* say that:

- Future similar lawsuits are possible, but unlikely;
- ED providers should watch the lawsuits closely, since FCA actions linked to EMTALA violations are theoretically possible;
- Refunding payments for encounters involving potential EMTALA violations eliminates liability under the FCA.

"To me, the most interesting part of the *Delta Regional* case is that the U.S. government did not bring the case."

It was the ED's trauma program manager who alleged that the hospital had created a de facto policy of not following EMTALA requirements for uninsured or Medicaid patients. "The employee attempted to profit by bringing a lawsuit for money and attorney's fees, and failed," Frew notes. Still, the fact the case was dismissed should not obscure an important message for EDs and hospitals.

"Intentional noncompliance with EMTALA is likely to offend the moral values of ED staff," Frew underscores.

Hospitals can expect any whistleblower report to result in a Centers for Medicare & Medicaid Services (CMS) investigation.

"That will be disruptive and potentially costly to the institution and can become the basis of malpractice claims against the physicians involved," Frew cautions.

When providing EMTALA training to employees, EDs and hospitals should instruct employees to call the compliance hotline or notify their supervisor about any EMTALA compliance concerns, Gutwald advises. Any retaliatory action against the whistleblower by the institution or the ED is an additional violation of EMTALA, Frew warns.

"Retaliation cases have resulted in successful suits in some cases," he says. In most *qui tam* cases, ED whistleblowers first brought their concerns to someone within their organization. Thus, says Adams, "it is almost always beneficial to have internal and meaningful avenues for employees to report complaints."

Citations Available Publicly

While EMTALA-related FCA claims appear unlikely, some plaintiff attorneys use EMTALA as a type of discovery mechanism successfully. "The client suffers some type of harm connected to an ED visit. The attorney advises the client to file an EMTALA complaint, which will result in a survey," Malone says.

If the survey identifies any deficiencies, the hospital's citation then becomes publicly available information. Evidence that someone failed to follow hospital policy can be useful in a medical malpractice case. "Some courts allow these reports to come into evidence. Others do not," Malone adds.

In Gutwald's experience, CMS investigators respond very favorably to hospitals that investigate potential EMTALA violations and proactively address any identified issues with updated training or policy changes. It is important that any internal investigation or corrective action is protected by one or more privileges, Gutwald cautions. These include peer review, attorney-client, or attorney work-product. A judge in a malpractice or EMTALA lawsuit probably would not admit evidence of an investigation or corrective action anyway.

"But being able to invoke the attorney-client privilege puts ED providers and hospitals in a stronger position to prevent that," Gutwald notes.

If an EMTALA complaint is made, investigators likely will review other ED charts. At that point, any unreported violations "can become very problematic," Gutwald says. "Repeated violations definitely make the imposition of fines and other penalties more likely." ■

REFERENCES

1. *United States ex rel. Vanderlan v. Jackson HMA LLC*, Civil Action No. 3:15-CV-767-DPJ-FKB (U.S. District Court, S.D. Mississippi, Northern Division, Sept. 14, 2018).
2. *United States ex rel. Sibley v. Delta Regional Medical Center*, Civil Action No. 4:17CV53-GHD-RP (U.S. District Court, S.D. Mississippi, Greenville Division, July 30, 2018).
3. *United States ex rel. Sibley v. Delta Regional Medical Center*, Civil No. 4:17-cv-000053-GHD-RP (U.S. District Court, Northern District of Mississippi, Greenville Division, March 21, 2019).
4. *United States ex rel. Vanderlan v. Jackson HMA, LLC et al.*, Case No. 3:15-cv-00767-DPJ-FKB. Motion to Dismiss, filed Nov. 15, 2018.
5. *Universal Health Services, Inc. v. United States ex rel. Escobar et al.*, No. 15-7 (U.S. Supreme Court, June 16, 2016).

Recent Data on Claim-Prone MDs Carry Many Legal Implications for EDs

Only 2.3% of physicians account for almost 40% of malpractice lawsuits

Did an emergency physician (EP) leave the hospital or staffing group suddenly after facing multiple malpractice lawsuits? If so, the obvious concern is whether a possibly negligent EP is putting patients at risk somewhere else.

"The conventional wisdom is that physicians who accumulate troubling medico-legal track records tend to move to other places where patients and colleagues don't know their reputation," says **David M. Studdert**, LLB, ScD, a professor of medicine and law at Stanford University.

Recently, Studdert and colleagues studied whether this long-standing concern is true.[1] They analyzed data from 480,894 physicians who had 68,956 paid claims from 2003 through 2015. The vast majority (89%) had no claims at all, and 8.8% had one. The remaining 2.3% had two or more claims, accounting for almost 40% of all claims.

The findings mirrored those of a 2016 study (on which Studdert worked, too) on characteristics of physicians with multiple malpractice claims.[2] In both studies, a very small group of physicians accounted for a disproportionately large share of lawsuits.

"We wanted to learn more about these 'frequent fliers,' particularly what happens to their practices over time," Studdert says.

Moving out of state used to allow claim-prone physicians to start with a clean slate when applying for a license or credential.

"In the late 1980s, there was such deep concern about this kind of behavior, and the threat it posed to the public, that Congress intervened," Studdert notes. The result was the National Practitioner Data Bank (NPDB), which requires reporting of malpractice payouts. Facilities are required to query the NPDB before granting privileges or hiring a physician. "It's clearly harder for physicians with bad records to escape their past than it once was," Studdert offers.

This might explain the study's finding that physicians with multiple malpractice claims do not relocate geographically any more often than their peers with no claims. "Frequent fliers were no more likely than physicians who did not experience claims to pick up and relocate for a fresh start elsewhere," Studdert says.

Physicians who accumulate claims are more likely than their peers to stop practicing medicine. "Nonetheless, the vast majority of them don't," Studdert adds.

More than 90% of physicians who racked up five or more paid claims continued to practice. "That is concerning," Studdert says. "Repeated paid claims against a practitioner are an important signal of patient safety risk."

Regulators, insurance companies, hospitals, and emergency medicine practice groups that hire or credential physicians all play a role in addressing this risk. "The more we learn about claim-prone practitioners, the clearer this imperative becomes," Studdert says.

Often, colleagues are in the best position to detect problems with care, Studdert adds "This is particularly true in highly collaborative environments like EDs."

Explore Med/Mal History

During the credentialing process, EPs are asked about any lawsuits or judgments against them. The credentialing committee considers whether to allow the request for privileges to continue to the medical executive committee.

"The medical staff office also assists with verification of credentials and clarifying if the license is restricted or not," says **Tiffany S. Hackett**, MD, MBA, an EP at Good Samaritan Hospital and director of leadership at Vituity, a Emeryville, CA-based provider of medical staffing services.

The process of identifying new legal action and credential verification occurs every two years. Hospital

EXECUTIVE SUMMARY

A tiny group of physicians accounts for almost 40% of malpractice claims, according to the authors of a recent study, but most continue to practice.

- Often, ED colleagues are in the best position to detect problems with care.
- Hospital leaders should look for repeated behaviors alleged in multiple cases.
- It is especially concerning if the EP settled multiple cases all with the same fact pattern.

bylaws also generally require EPs to report any new legal action to the hospital and medical executive committee.

"There should be a compelling reason to justify someone being sued repeatedly having privileges extended or renewed," Hackett says.

Of course, multiple lawsuits against an EP do not necessarily mean malpractice occurred. The mere fact that an EP was sued "should not and does not automatically prevent someone from being privileged," Hackett notes. "Rather, that fact should give credentialers pause and lead them to find out more."

Sometimes, EPs are named in lawsuits just because they were on shift at the time of the plaintiff's ED visit, even though they were in no way involved in the plaintiff's care. Similarly, a patient's bad outcome on an inpatient floor might have had nothing to do with the care provided in the ED. Typically, until discovery proves otherwise, everyone involved in the patient's care is named. In some cases, baseless claims are settled because the potential for damages is high, necessitating a NPDB report. "Other times, the litigation costs far outweigh a settlement," Hackett adds.

EPs are "ripe targets for disaffected patients disappointed with their medical outcomes. The bar to getting sued is very low," notes **David S. Waxman**, JD, an attorney in the Chicago office of Saul Ewing Arnstein & Lehr. Even if a case is thrown out at the most preliminary stage, any EP named is required to report it when seeking insurance or staff privileges. Still, the facts behind any EP named in multiple cases are worthy of investigation. Any provider's malpractice history likely is discoverable.

"Thus, a hospital should always have a detailed understanding of when and why its physicians are named in suits," Waxman adds.

Similar Allegations Worrisome

If an EP defendant's concerning malpractice history becomes an issue during litigation, it means the hospital also is legally exposed. Plaintiff attorneys can explore whether the hospital's medical executive committee carried out due diligence in sorting out the facts behind frequent claims.

"Lack of documentation of a thorough vetting process by the medical staff may put the hospital at risk," Hackett says.

Hospital leaders should be on the lookout for repeated behaviors alleged in multiple cases, Waxman says. The EP may have failed to administer a certain medication or failed to recognize a particular condition that requires referral to a specialist. If troublesome practices are detected, "QA and risk management should be involved, but in a manner that preserves confidentiality and/or privilege," Waxman offers.

Multiple settlements are especially concerning.

"Generally speaking, more than bad luck is involved," Waxman says. Many previous payouts by the EP defendant can shift the focus to the hospital. "It means that on different occasions, someone — whether a hospital, the insurer, or a jury — has decided that the care provided by that physician could be sufficiently challenged to justify payment," Waxman says.

For hospitals or ED groups, it is legally problematic if an EP's previous lawsuits demonstrated the same fact pattern.

"The plaintiff could claim there was sufficient notice that there was something about the care being provided by that particular physician that was potentially endangering patients and required some type of intervention," Waxman explains. For instance, multiple successful lawsuits alleging the EP misdiagnosed myocardial infarction or stroke are red flags.

"The hospital's failure to take action on that physician's privileges could result in a negligent credentialing claim against it," Waxman warns.

That litigation history becomes admissible in any future case involving the hospital's credentialing decisions. For this reason, says Waxman, "it is incumbent upon a hospital to sift through the noise of the inventory of lawsuits against it and its physicians and discover where true quality of care issues may leave it exposed." ■

REFERENCES

1. Studdert DM, Spittal MJ, Zhang Y, et al. Changes in practice among physicians with malpractice claims. *N Engl J Med* 2019; 380:1247-1255.
2. Studdert DM, Bismark MM, Mello MM, et al. Prevalence and characteristics of physicians prone to malpractice claims. *N Engl J Med* 2016;374:354-362.

COMING IN FUTURE MONTHS

- Factors that make ED's QA process discoverable
- How plaintiff attorneys prove inadequate triage
- What happens when an EP fails to obtain consult?
- Essential documentation for AMA patients

Security Footage of ED Waiting Room Likely Admissible

Such evidence can lead to grave outcomes for the defense

In some highly publicized malpractice cases involving the ED, no one had to wonder what happened right before the patient died; the hospital's security camera in the waiting room captured it all.

"A video of this type would be catastrophic for the defense, if admitted," says **Dan Groszkruger**, principal of Solana Beach, CA-based rskmgmt.inc.

In an infamous case from July 2008, footage captured in a Brooklyn psychiatric hospital not only showed a patient collapsing on the floor of a waiting room, it also provided evidence of exactly how long she remained on the floor without anyone examining or treating her. "The video was both relevant and persuasive evidence of neglect," Groszkruger says.

Not all such cases are well-publicized. Groszkruger is aware of another similar case in which security cameras documented apparent neglect or delay when a patient suddenly deteriorated, seemingly ignored by ED staff. In that case, the patient was revived but expired later due to her underlying condition. The case settled before evidentiary issues were presented to the court, so it is unclear how the judge might have ruled as to the videotape's admissibility.

"But the important message is that if you have such a videotape, the mere possibility of its admission at trial is often sufficient to motivate the defendants to settle," Groszkruger cautions.

Admissible, or Not?

Does an ED nurse claim she reassessed the patient at regular intervals, but the family says their loved one's deteriorating condition was totally ignored?

"The issue is generally what a reasonably attentive and competent clinician would be expected to do if a patient were to faint, collapse to the floor, complain loudly about severe symptoms, or something of the like," Groszkruger explains.

If the response in the waiting room is in dispute, security videos are a seemingly impartial source potentially available to litigants on both sides. "It could be important if the patient alleges he or she was not reassessed by the ED staff, or that the patient waited an enormous amount of time for a serious condition that led to a bad outcome," says **Robert D. Kreisman**, JD, a Chicago-based malpractice attorney.

However, ED waiting room tapes cannot be used if they do not exist. "From the plaintiff's point of view, the struggle might be how to preserve the video footage from either being destroyed or taped over, if not requested early on," Kreisman notes.

Assuming the ED waiting room footage exists, generally, it is admissible in a malpractice lawsuit, according to Groszkruger. Still, the defense can argue vehemently it should be inadmissible. Patient privacy regulations are one obvious concern if other individuals are visible. The court may require video to be converted to still photographs or edited to eliminate all irrelevant events. "The footage could be edited in such a way as to delete or mask others pictured," Kreisman adds.

The defense may try another tactic by arguing that the footage should not be admissible because it is not clear that ED providers could observe the event. "In many large ED waiting areas, no ED staff member can observe every event in every part of the waiting area," Groszkruger says. Therefore, the physical layout of the ED becomes critical.

Whether security tape footage is admissible evidence in a particular court trial is determined by the rules of evidence that govern that court jurisdiction, says **Shane C. Sidebottom**, Esq., a healthcare attorney with Ziegler & Schneider in Covington, KY.

"A very crucial issue to admit any video evidence into a court

EXECUTIVE SUMMARY

Hospital security footage of ED waiting rooms can play a pivotal role in malpractice litigation. Some factors that can determine the admissibility of this footage:

- Visibility of other individuals;
- The ED's physical layout in terms of making the event observable;
- The fact that time-lapse recordings were used.

record is that it must be properly authenticated," Sidebottom says. Generally, authentication requires a witness who recorded the video (or operated the system that recorded the video) to testify under oath that the video is true and genuine. In the case of hospital security footage, says Sidebottom, "it is helpful that there are policies and procedures in place that govern how recordings are made and stored in the organization to establish authenticity."

Although video evidence can persuade a jury at trial, the way the footage is generated can mean they never see it. "One particular issue that I have seen with security cameras that can cause evidentiary issues is if they are on a time-lapse recording delay," Sidebottom says. For example, a camera that records on and off every few seconds can be thrown out as evidence. "It cannot provide real-time accuracy of the event in question," Sidebottom explains.

Reasonable Expectation

More EDs are using video security cameras as a possible deterrent to violence. "However, it creates a conundrum with regard to the extent to which it might be used in a medical malpractice situation," says **Andrew P. Garlisi**, MD, MPH, MBA, VAQSF, medical director of Geauga County EMS and University Hospitals' EMS Institute Paramedic Training Program in Ohio.

In the example of a patient collapsing in the waiting area, the video footage could document the following clearly:

- Duration of waiting time;
- Patient reassessments (if any) by triage nurse;
- Elapsed time from collapse to medical intervention.

"Depending on the etiology and consequences of the collapse, a medical malpractice action might be inevitable," Garlisi says. If the patient expired due to a lethal arrhythmia, one could argue the patient with dizziness should have been placed on a cardiac monitor, since cardiac arrhythmia is on the differential diagnosis list of dizziness. "In this worst-case scenario, it would be likely that security footage could be submitted as evidence on behalf of plaintiff," Garlisi says.

If ED waiting room videos are posted on social media, the defense likely will argue that it created bias against the defendant. "Most likely, the jury would be screened as to whether or not they had viewed the footage prior to trial," Garlisi notes. Is anyone monitoring the video footage in real time? This becomes another important question during litigation. If the answer is no, Garlisi says, the next question will become: "If no one is continuously monitoring the footage, how it is possible to provide timely intervention in the event of a crisis?"

On the other hand, security footage potentially can refute allegations that the patient was ignored. For instance, the footage might show the triage nurse conducting regular assessments. The opposite holds true if the tape shows nobody reassessed the patient. "The family members who claim that the patient was ignored will be given credence," Garlisi says.

The defense always can argue ED providers were unaware the patient was deteriorating in a crowded waiting room. "Unfortunately, for the emergency team and the hospital, being short-staffed and too busy most likely will not exonerate the defense in a tragic, preventable death in the ED waiting area," Garlisi cautions.

Patients expect to receive an adequate assessment as often as necessary to ensure their safety. "This is a reasonable expectation," Garlisi adds. ■

Potential Liability Exposure for EDs Regarding HHS Conscience Rule

ED providers and hospitals may face potential liability risks stemming from the "conscience rule" recently issued by the U.S. Department of Health and Human Services' (HHS) Office for Civil Rights, says **Rade Vukmir**, MD, JD, FACEP, FACHE.[1] The rule could trigger EMTALA violations if patients who require emergency medical attention are refused care, according to a joint position statement from the American College of Emergency Physicians and the Emergency Medicine Residents' Association.[2]

"We are America's safety net, we are always available, and, thankfully, we can provide care initially without worrying about insurance, ability to pay, or belief systems for that matter," Vukmir says. For EPs, the intent always is to provide high-quality and uniform care to patients "without any uncertainty on their end or our end," says Vukmir, president of Critical Care Medicine Associates, a medical risk management consulting firm. Vukmir is also clinical professor of emergency medicine at Temple

University and Drexel University. Under EMTALA, EDs are obligated to provide stabilizing treatment for emergency medical conditions, regardless of the ability to pay, and transfer the patient if another level of care is required. If the HHS rule causes a provider to refuse to provide such care to a patient, this is, of course, a potential EMTALA violation. However, the rule should not change anything in terms of the care provided in EDs.

"We expect our providers to provide standardized care for all of the conditions we encounter," Vukmir says. "This codification of previous laws is not going to change that."

The HHS rule protects providers who cite religious or moral objections to providing certain services.

"But it really could be on both sides. It also provides a pathway for patients, as well as healthcare providers, to raise concerns," Vukmir offers.

A patient or family might decide to call a lawyer if they perceive, rightly or not, that the care they received in the ED was substandard due to a provider's invoking the HHS rule. This kind of scenario could occur if a sexual assault victim asks for emergency contraception when presenting to an ED at a faith-based institution.

"Most institutions have procedures and protocols in place to provide all necessary federally mandated patient care," Vukmir notes.

However, if an ED provider objects to the provision of emergency contraception, Vukmir says, it is important for that provider to inform the hospital system or ED group in advance so that an alternative plan can be made.

"We don't want to react to this issue necessarily when it occurs," he says. "Proactive protocols in place before the event are typically the best approach."

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Education of ED providers is important to avoid misunderstandings that can end up in court.

"We need to tell people what this new statute is and, as importantly, what it isn't. It's not meant to be a carte blanche for the provider to 'do what you want,'" Vukmir says. It is important that ED providers understand the HHS rule is "not an option to proselytize. It's not our place to try to convince patients of our moral rightness, or vice versa," Vukmir notes.

When it comes to a patient or family calling a malpractice attorney, perception can be just as important as reality. If someone perceives a provider is judging him or her, says Vukmir, "they may feel all their care is tainted. People might worry that this is a license for providers to somehow restrict their care."

Plaintiff attorneys might allege that a patient received lower-quality care in an ED because he or she was uninsured. It is possible that plaintiff attorneys may claim similarly the patient received substandard care due to a provider's belief systems and invocation of the conscience rule.

"We don't want any patient to perceive that because of their set of circumstances that are in conflict with a provider's beliefs, the provider now has free rein to do what they want," says Vukmir, emphasizing that all ED patients have "a long-standing, codified right to receive a uniform standard of care no matter the circumstances. The HHS rule doesn't change that in the least." ■

REFERENCES

1. American College of Emergency Physicians. Emergency Physicians: HHS Conscience Rule Puts Patient Safety At Risk, May 3, 2019. Available at: http://bit.ly/31dpXky. Accessed June 6, 2019.
2. U.S. Department of Health & Human Services, Office for Civil Rights. 84 FR 23170. Issued May 21, 2019. Available at: http://bit.ly/2WKgnpW. Accessed June 6, 2019.

CME/CE OBJECTIVES

After completing this activity, participants will be able to:

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

Metadata Find Way Into ED Malpractice Litigation

During the course of ED malpractice litigation, metadata are becoming an issue in one way or another. It can help ED providers, hospitals, or plaintiffs prevail, assuming the information can be interpreted correctly.

"It may be difficult to determine the facts of the case because metadata can be very confusing," says **Ken Zafren**, MD, FAAEM, FACEP, FAWM, clinical professor in the department of emergency medicine at Stanford University Medical Center. Zafren also is an EP at Alaska Native Medical Center in Anchorage and former emergency programs medical director for the state.

Metadata are especially useful in ED claims alleging delayed evaluation or treatment of a time-dependent diagnosis. This information is used to confirm or disprove that there was a delay. In one such case, an EP ordered morphine for a patient who had suffered a previous severe reaction to morphine that was documented in the ED chart.

"The patient's family had told the nurses and the doctor that the patient nearly died one time after receiving intravenous morphine," Zafren says.

Nonetheless, the EP ordered morphine to be given intravenously to the patient, who was complaining of severe chest pain.

According to the metadata, morphine was ordered at 7:07 a.m. The patient developed supraventricular tachycardia at 7:10 a.m., for which he received multiple doses of adenosine.

"The family member who accompanied the patient said he had an almost immediate reaction after receiving the morphine," Zafren notes.

However, the metadata indicated that the morphine was administered at 7:55 a.m. "This is unlikely, not only due to the urgency of treating severe chest pain and the family member's account, but also because the metadata show that the pharmacist voided the order for morphine at 7:30 a.m.," Zafren explains.

It is unlikely that an ED nurse would have administered morphine after the order was voided, Zafren says. After 7:10 a.m., the patient continued to deteriorate hemodynamically and developed further arrhythmias and hypotension. He became unresponsive and required intubation, and was admitted to the ICU for several days.

Both sides attempted to use the metadata to their advantage. The defense used it to claim that the patient had not had a reaction to the morphine. The plaintiff's expert countered that the metadata showing that morphine was administered 48 minutes after the order and 45 minutes after the onset of supraventricular tachycardia most likely were incorrect.

"In the end, the metadata were helpful to the plaintiffs," Zafren adds. "The case settled for an undisclosed amount."

In another malpractice case, metadata also proved devastating to the defense. Neurological checks were ordered to be performed every 15 minutes on a patient who was taking aspirin, clopidogrel, and warfarin and who fell, striking his head. The chart indicated the neuro checks occurred at exact 15-minute intervals (on the hour, and 15, 30, and 45 minutes after the hour).

The metadata revealed that all the entries were made by the same nurse hours later, after the patient had died already at a nearby hospital due to intracranial hemorrhage. "The metadata were not believable," Zafren says. Based partly on the late documentation that appeared to have been fabricated or at least altered, the physician defendant settled on favorable terms for the plaintiffs.

On the other hand, metadata can help the defense team by showing that the standard of care was met. A fatal case of pediatric cardiomyopathy involving ED care showed that everything was handled correctly. The case was reviewed by three experts, including Zafren.

"The plaintiff's attorney was not surprised when I told him that the care the unfortunate child received was exemplary because the other two experts had already told him the same thing," Zafren recalls.

The plaintiff attorney wanted to be absolutely sure there had been no breach in the standard of care. This way, he would know he had done everything possible for the understandably very distraught family.

"The metadata showed an amazingly robust and timely response to a child who was deteriorating very rapidly," Zafren says. "A lawsuit was never filed."

The plaintiff attorney asked Zafren to write a short letter stating what he had found after reviewing the care, that the standard of care was met (although the patient died). This information was a possible source of comfort to the family.

"I think it is easier to accept the death of a loved one due to a disease or injury in spite of receiving the best care than to know that the patient might have survived with better care," Zafren offers. ■

ED LEGAL LETTER™

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CME/CE QUESTIONS

1. **Recent False Claims Act (FCA) lawsuits regarding EMTALA alleged that the hospital:**

   a. violated EMTALA, rendering patient bills to the federal government actionable under the FCA.
   b. attempted to conceal the inappropriate transfer of unstable patients by not billing for the services provided.
   c. double-billed for some medical screening examinations.
   d. turned patients away whose insurance was out of network.

2. **Which is true regarding hospitals' legal exposure with frequently sued EPs?**

   a. Hospitals are no longer required to query the National Practitioner Data Bank for payouts less than $50,000.
   b. Generally, hospital bylaws require EPs to report any new legal action to the medical executive committee.
   c. Whether the EP's privileges are renewed despite a successful lawsuit is determined based on the payout amount.
   d. Several successful paid claims automatically prevent the renewal of an EP's privileges in most hospital bylaws.

3. **Which is true regarding the requirement for videos to be authenticated?**

   a. Unlike other forms of evidence, courts do not require videos to be authenticated.
   b. Authentication of waiting room footage can only be handled by hospital administrators.
   c. The individual who recorded the video, or operated the system that recorded the video, generally is required to testify under oath that the video is true and genuine.
   d. Hospital policies governing how recordings are made and stored in the organization are enough to establish authenticity.