ED LEGAL LETTER™

THE ESSENTIAL RESOURCE FOR EMERGENCY MEDICINE MALPRACTICE PREVENTION AND RISK MANAGEMENT

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INSIDE

Plaintiff Attorneys Hunting for Social Media Posts Made by ED Staff, Expert Witnesses

Social media posts may be intended just for the eyes of co-workers, friends, or family. However, an attorney could use such posts against the hospital in malpractice litigation.

"Many posts are made in frustration and at an emotional level, without thinking of the legal and regulatory implications," says **Michael Blaivas**, MD, FACEP, FAIUM, an affiliate professor of medicine at University of South Carolina School of Medicine.

Blaivas has seen all kinds of problematic posts made by ED staff: Laboratory turnaround times are too long, individual emergency physicians (EPs) are incompetent, equipment is in bad shape, and more. Lawyers are getting better at finding those kinds of social media posts made by anyone even tangentially involved in the case.

"Particularly skilled attorneys will know how to exploit them," Blaivas says. "This is being done not just at the larger, well-staffed firms, but by anybody with an assistant."

Inflammatory posts do tend to receive a stronger focus in weaker malpractice claims. "When the case has little merit, they are much more likely to look for jury distractions," Blaivas observes.

Once they find the ED-related social media posts, plaintiff attorneys can use them in some surprising ways. An ED nurse might have posted an offhand comment about how it was a shame a deteriorating patient was ignored in the waiting room. "The plaintiff attorney can claim that you or somebody else was talking about this very case on that day," Blaivas says.

Depending on the issue, the post could be a way to bring the hospital into the litigation. If based on state laws, the hospital ordinarily would not be liable for an EP's malpractice. A relevant social media post could change that. "Sometimes, the laws make it very difficult to go after the hospital for anything significant. But you have now handed the plaintiff attorney an easy recipe for going after the hospital,"

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Blaivas says. The social media post could cause other types of legal problems. "Sometimes, it means that different kinds of claims are now available to the plaintiff, in addition to malpractice claims," Blaivas explains.

The post could lead the hospital into trouble with regulatory agencies. If someone posts photographs of celebrity ED patients without permission, the hospital could find itself under investigation for a HIPAA violation. If someone posts, "Another patient with COVID-19 was turned away," it could be reported directly to CMS as a possible EMTALA violation, says **Danielle M. Trostorff**, Esq., a health law specialist at Degan, Blanchard & Nash in New Orleans.

Some posts blatantly accuse the hospital of patient dumping or demanding payment before a medical screening exam is performed, implying an EMTALA violation. "In the first months of COVID, this was an issue as hospitals struggled to find ICU beds in other cities or locations," Blaivas notes.

Blaivas is aware of a social media post from an EP who made derogatory comments about a patient who experienced a poor outcome in the ED, which resulted in litigation. Any careless comments that could be alleged to relate to race, gender, disability, or sexual orientation "will be very challenging right now," Blaivas cautions. "Attorneys will stretch statements out of context to the fullest."

Any social media post that talks about inadequate staffing, lack of resources, equipment shortages, or the quality of care given to patients by certain ED providers opens up potential areas of liability for hospitals. "Perhaps you are unhappy with the way nurse X or Dr. X treats patients. If you question their competency or suspect malicious intent, those kinds of posts can really come back to haunt people," Blaivas says. If the jury sees the posts, the defense team is stuck trying to disprove the inflammatory statements in court. The plaintiff attorney will ask questions such as "Was anyone else in the hospital aware of it?" or "Was there a cover-up?"

If a person complained in a social media post that the ED waiting room is constantly packed, the defense can assert the same is true of most EDs. "It would be easy to make the case to the jury that everyone is in the same boat. Show me a facility that doesn't have crowding issues," Blaivas offers.

Plaintiff attorneys could counter this by displaying billboards from competitors during the same period listing short ED wait times, or advertisements inviting people to make appointments for ED visits and be seen in 10 minutes or less. The attorney could contrast these marketing messages with the social media post describing a packed waiting room. "They will say, 'Other EDs don't have these issues. What's wrong with your ED?'" Blaivas says.

Blaivas has seen several ED experts discredited because of unearthed posts that undermined his or her testimony in some way. One expert posted statements passionately in favor of tort reform. Another made derogatory comments about patients who sue their providers. "All of that can come up at your deposition, or at trial," Blaivas says. "That can really derail cases."

The expert witness is blindsided by a random post suddenly brought up in court. "Attorneys attack quite aggressively, trying to spin things," Blaivas says.

One way to mitigate risk is for ED providers to never post anything

work-related, or to invest in a service that flags all their posts for any possible negative connotations.

"It's difficult to get people to think twice about what they post, or to use a system that filters their social media. But clearly, it's needed," Blaivas notes.

Any post made by an ED employee about the department, the hospital, or anything that occurred there could be discoverable as evidence in any lawsuit, says **Shane C. Sidebottom**, Esq., an attorney at Covington, KY-based Ziegler & Schneider. "Most jurisdictions will allow parties to seek discovery from a wide range of sources so long as it is relevant to a lawsuit," Sidebottom explains.

For instance, if an ED nurse posts something negative, it is likely to be discoverable and could be used as evidence in a legal proceeding. "Generally, it is good practice for any business to have established social media policies for their employees about issuing social media posts related to their job," Sidebottom suggests.

Trostorff says hospital social media policies usually forbid anyone from posting patient information or photographs online. In fact, the policies may forbid using any cellphones or cameras in the hospital at all. The policies also may forbid anyone from disclosing hospital proprietary business. This includes financial reports, budgetary information, workplace issues, utilization review, quality assurance, incident reports, adverse events, near misses, and credentialing.

"The consequences of violating social media policies can include disciplinary action, licensure action, [and] civil and criminal penalties," Trostorff says.

In contrast, a hospital could argue safety concerns reported through appropriate channels are free from disclosure in a malpractice case. The hospital would move to limit discovery and seek a protective order against disclosure. "It is important that hospitals have procedures in place to keep proprietary and confidential patient care, peer review, and other protected reportable information separate from disclosure," Trostorff says.

During the COVID-19 pandemic, some ED providers disregarded hospital policies on social media posts, and openly complained the department was unprepared. "Hospitals may say, 'We have this clause in your contract stating that you can't be on social media disparaging our institution,'" says **Rade Vukmir**, MD, JD, FACEP, FACHE, president of Critical Care Medicine Associates.

Once someone does post, the question becomes whether it is admitted as valid evidence or is excluded as hearsay. "There's a little bit of a balance here," Vukmir observes.

If it is publicly posted, it is admissible, as there is no expectation of privacy. If it is privately posted, it is more of a grey area. "If somebody within your private network releases the information, it may not be private anymore. Some people may not recognize that," Vukmir says.

The court might set that post apart for an evidentiary hearing or for a separate discussion just on admissibility of that piece of evidence. "It's all about balancing vs. discrimination value of allowing the evidence to be considered," Vukmir says.

Some attorneys try to access private posts deceitfully, such as by asking someone from the office to "friend" the person through social media. "If somebody tries to get the information under false pretenses, that typically will not be admissible," Vukmir explains. "You can't be underhanded about it."

Still, attorneys are actively hiring third-party abstraction firms to scour social media sites for anything that could strengthen their cases. Additionally, once something is posted, it is permanent. It is fair game for lawyers to access it, even if it has to be handled by forensic retrieval analysis or subpoenaing the deleted posts for the site. If someone regrets a publicly posted comment and deletes it, says Vukmir, "it was up and it existed; technically, this may be viewed as destruction of evidence." ■

Jury Might Scrutinize Hospital Response to Safety Concerns

ED providers have claimed they were fired or disciplined because they reported safety concerns during the COVID-19 pandemic, with the American College of Emergency Physicians and the American Nurses Association condemning these reports as early as March and April.[1,2]

When these types of issues are reported, "the way hospitals respond has to be done with one eye on how an average jury is going to view your response," says **Sean R. Gallagher**, JD, an attorney at Denver-based Polsinelli.

If an ED employee is terminated in retaliation for blowing the whistle on health and safety issues, that employee will have a claim for wrongful termination.[3] "We refer to them as public policy discharge claims," Gallagher explains.

In these claims, the plaintiff alleges he or she reported health and safety concerns to the proper authorities (either within or outside the hospital), and leaders terminated their employment in retaliation for reporting those concerns.

The law says an employee can be fired for any reason as long as it is not discriminatory. "But people on juries don't think that's the rule," Gallagher observes.

Most jurors believe employees are entitled to due process, whereby the appropriate parties address concerns and performance issues properly.

"When hospitals are dealing with whistleblowers, the challenge is to respond in a way that's effective, but also gives you a good story to tell to a jury," Gallagher says.

The hospital probably cannot disclose specifics on how the concern was investigated, but can at least give a general idea of what it entailed. Administrators could explain there was a meeting with all involved parties in attendance, that a specific number of people were interviewed about the concern, that there was a written report prepared, and that a medical review board of credentialed physicians made a determination. Showing the decision to terminate or discipline the employee was a group decision (as opposed to an individual mandate) is especially important.

"It's much more difficult for the employee to show that a whole committee of people was out to get him or her," Gallagher reports.

From the ED provider's perspective, the more specific the complaint is, the better the chances the hospital will act on it. A complaint such as "I don't think we have appropriate staffing levels within the ED. I complained to my boss but nothing was done, and I think they retaliated against me" is too general.

A detail-rich complaint with data is far more effective, such as: "I compared the staff level from 2019 to 2020. The number of employees in the ED during any given shift was down by 12%. Volume was 15% higher than it was a year earlier. I complained on March 25 to my supervisor, and then complained to the internal anonymous complaint hotline. Following that, I was transferred from day shift to night shift by the people responsible for staffing the ED."

It is always possible there was a good reason an ED nurse was put on the night shift. The problem is the employee does not always know the reason — and assumes the worst. "What's interpreted as retaliation may not be that at all," Gallagher observes. Lawyers see fewer whistleblower cases when the economy is booming and the job market is great.

"But when layoffs are happening, and it is much more difficult to become re-employed, you find employees who are trying to protect their existing job," Gallagher notes.

Employees may file complaints internally at the hospital, or go external right away by contacting regulatory agencies, the media, or elected officials.

"We haven't yet seen a large wave of post-pandemic employment litigation. But that's not to say it isn't coming," Gallagher suggests. Most courts have been closed, and only some are starting to re-open.

Traditionally, if an employee is injured in the workplace, the only remedy was filing a workers' comp claim.

"As we all know, nobody ever got rich by filing a workers' comp claim and cashing the check," Gallagher says.

One way around that limitation is for employees to claim they were terminated because they blew the whistle on misconduct in the workplace. "Employment lawyers like to bring those cases, as the employee can potentially recover more than if you went through the worker's comp system," Gallagher explains.

The employment bar also expects to find sympathetic juries who remember what things were like during the pandemic. If an ED nurse complains about understaffing, the nurse would not have a claim against the hospital for having to work in those conditions. However, if the nurse suffered an adverse job action he or she believed was related to voicing those concerns, then that would be a potential wrongful

termination claim. Some of those claims are filed specifically because the employee thinks no one acted on his or her complaint.

"Employers often drop the ball. They do exactly what they should be doing to investigate, but don't go back to close the loop to whoever raised the concerns and tell them what was done," Gallagher says.

Right from the start of some depositions, it is clear all the employee wants is for somebody in an authority position to listen.

"It's cathartic," Gallagher says. "Once they've done that, [employees] are more willing to talk about resolving their dispute."

As for how ED whistleblower cases will turn out, "the answer to this question will also be both state- and fact-specific," says **David B. Honig**, JD, an attorney in the Indianapolis office of Hall Render.

Some states offer whistleblower protection and additional cover for employees. Others are "right to work" states with almost no employee shield. "That said, a disgruntled healthcare employee always carries an additional risk beyond reporting of safety concerns," Honig says.

The employee could argue the discharge was in retaliation for identifying fraud, that the safety risk was so bad it made the claims to a government payer fraudulent.

"This, as well as any related allegations that there was fraudulent billing, falls under the federal False Claims Act and related state false claims acts," Honig explains. ■

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Missed Appendicitis ED Claims Follow Similar Fact Patterns

The authors of a recent study learned missing appendicitis was more likely to occur among patients with comorbidities, women, and patients who experienced abdominal pain accompanied by constipation.[1]

"The ED is particularly vulnerable to diagnostic errors due to time-pressured decision-making, lack of complete information, frequent interruptions, and the need for accurate and timely diagnosis," says **Fernanda Bellolio**, MD, MS, one of the study's authors.

Often, decisions are made with inadequate information.

"Appendicitis is a good example of a disease that, at the time of presentation to the ED, patients may be in an early and incompletely evolved disease state. That could change quickly," says Bellolio, a professor of emergency medicine and research chair in the department of emergency medicine at Mayo Clinic in Rochester, MN.

Bellolio and colleagues analyzed insurance claims data from 2019 involving patients who presented to the ED with undifferentiated symptoms associated with appendicitis. Of 123,711 patients who were ultimately diagnosed with appendicitis, it was potentially missed in 6% of adults and 4.4% of children. "Because it is a retrospective analysis, we say these are potentially missed," Bellolio explains.

Some patients presented more than once to the ED with similar complaints, but it is unclear whether the appendicitis diagnosis could have been made at the time of the first visit. Overdiagnosis puts patients at risk for unnecessary interventions. "However, greater attention has gone into underdiagnosis or missed diagnoses, which may result in morbidity or mortality that could have been avoided with timely diagnosis," Bellolio suggests.

Bellolio and colleagues set out to pinpoint factors associated with a potentially missed diagnosis of appendicitis in the ED. "We see many patients coming with abdominal pain. We need to identify the minority that will have a surgical pathology like appendicitis," Bellolio says.

The answer is not always more diagnostic testing. The authors cautioned against overuse of CT scans for abdominal pain patients, particularly for young patients. Even among those who underwent CT scans, there were potentially missed appendicitis cases, Bellolio notes.

The vast majority of the adults with same-day diagnosis underwent CT scans, but most of the missed appendicitis cases had undergone CT scans, too. "We need to weigh the

risk and benefits with each patient, and keep our clinical suspicion high," Bellolio explains.

Most patients with potentially missed appendicitis were constipated. "We noticed that the use of abdominal X-ray was unhelpful and more likely to mislead providers," Bellolio reports. Seeing stool burden in an X-ray does not mean abdominal pain is caused by constipation. Abdominal X-rays should be used to rule out ingested foreign bodies, says Bellolio, "but otherwise, it is misleading and causes confirmation bias."

Amy Evans, JD, says missed appendicitis cases usually follow a similar fact pattern. The patient comes to the ED early in the disease process. The ED provider diagnoses gastroenteritis or constipation based on the presence of fecal material on X-rays and/or a patient reporting no recent bowel movements. The patient is discharged with standard follow-up instructions for gastroenteritis or constipation. The patient returns a few days later with a ruptured appendix and peritonitis, requiring an open procedure as opposed to a laparoscopic procedure.

"Liability can be mitigated or prevented through careful discharge instructions," says Evans, executive vice president of business development and liability claims division at Intercare Insurance Services in Bellevue, WA.

For the best possible defense, these instructions should include directives to return if pain does not resolve in 24 hours, or if the patient develops chill, fever, loss of appetite, nausea, vomiting, or diarrhea. "Detailed discharge instructions with close post-discharge follow-up is important to mitigate risk," Evans adds. ■

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Suspicious Changes to ED Chart Become Central Focus of Malpractice Lawsuit

During litigation involving a missed sepsis claim, it became painfully obvious the EP defendant had altered the medical record to cover up a mistake.

"It became the entire focus of the case," says **Matthew P. Keris**, Esq., a shareholder in the Scranton, PA, office of Marshall Dennehey and chair of the firm's electronic medical record and audit trail litigation practice group.

There were three defendants named in the lawsuit: The hospital (who Keris represented), the EP, and the patient's surgeon (other attorneys represented the latter two parties). The patient was obese, with a history of reconstructive abdominal surgery, and felt a "pop." The patient went to the ED, where an EP handled the workup and learned the surgical history. Ultimately, the EP discharged the patient home. "Unfortunately, the patient had a small bowel obstruction that went undiagnosed," Keris reports.

Days later, the patient returned to the ED in terrible pain. During subsequent surgery, the patient died. After the initial ED visit, the EP's note was auto-faxed to the surgeon's office. In that note, the EP stated they talked about the case briefly, and that the patient was told to return to the ED if his problems persisted.

When the patient came back dangerously septic, the EP did not see the patient but was aware the patient had returned terribly ill. The EP went back into the EHR, deleted what he had documented (which, unknown to him, had been auto-faxed to the surgeon), and charted a much more detailed account of the conversation. "Frankly, even at the outset of the case, it looked very self-serving," Keris offers.

Among other things, the EP documented, "Had a long discussion with the surgeon about the patient's condition. The surgeon agrees with me that the patient most likely does not have a small bowel obstruction. He agreed that the patient should be discharged home, and agreed to see the patient in a few days." The suspicious entry coincided exactly with the time the patient was admitted for sepsis.

The patient's family sued both physicians and the hospital. The complaint included several allegations:

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• The conduct of the physicians delayed the diagnosis and treatment of a small bowel obstruction;

• By the time the patient returned to the ED, he was septic and had a much worse chance of survival;

• If the EP and surgeon had admitted the patient to the hospital during the initial ED visit, he would have lived, since at that time the only signs of a small bowel obstruction were diminished bowel sounds and concerns about the "pop" the patient had felt previously.

At deposition, the surgeon was confronted with the ED record, and strongly refuted the EP's account. The surgeon testified he actually told the EP that while the patient had been seen by the surgeon in the past, his office had discharged him some time ago, in part because of thousands of dollars of unpaid bills. The surgeon further stated he wanted nothing to do with consulting on this particular patient. "There was no way to reconcile their stories. None," Keris says.

It became apparent the hospital did not know about the content of the auto-faxed note to the surgeon. The hospital only had the altered entry in their chart, not the first entry (because the EP had deleted it and retyped a new entry).

The situation grew even worse for the EP when the plaintiff attorney requested the electronic tracking of the surgeon's ID badge. It turned out the surgeon was at the hospital making rounds during the patient's first ED visit, after the phone call. The surgeon never came to the ED to see the patient.

"The surgeon stated that if he intended on seeing the patient on an outpatient basis, he would have seen the patient in the ED while he was in the hospital making rounds," Keris notes.

Phone records showed the call lasted three minutes. The surgeon contended that if the detailed discussion really happened as the EP claimed, the call would have lasted a lot longer. "The entire trial was basically a credibility contest for the jury," Keris says.

The jury had to decide who to believe. Either the EP really did engage in a long conversation with the prior surgeon, which would give the EP a viable defense, or the surgeon was the one telling the truth.

Suddenly, the story took a bizarre turn. The EP defendant left the ED practice group, and started working at a different hospital — soon after which he was fired. "He was caught stealing stethoscopes," Keris says.

There was incriminating evidence, since one of the stolen stethoscopes included an engraving of a nurse's initials. After hospital security found the stethoscope in his car, the EP pled guilty to theft.

"We did not know if the plaintiff lawyer was aware of that, right up until the eve of trial," Keris says. It soon became apparent the plaintiff attorney did know all about the theft, and presented it as evidence to the jury. "The jury was permitted to consider the conviction in determining who was more truthful," Keris says.

Even after this damning evidence came to light, the insurance company adjustor for the EP held off on the decision on whether to settle the claim until the surgeon testified. "It wasn't until after the surgeon was on the stand and gave his version of events that the case settled," Keris adds.

Sandra M. Douglas, JD, an attorney in the Richmond, VA, office of Hancock, Daniel & Johnson, has seen these examples of late charting in ED malpractice cases:

• After a patient returned to an ED the following day in cardiac arrest, an autopsy identified physical injuries that were not documented during the first ED visit. The EP went back in the EHR and charted that he found physical injuries after examining the patient during the first visit.

• In a case of failure to diagnose meningitis, the EP went back in the EHR after the patient's subsequent demise. The EP added a detailed physical and neurological examination that conflicted with the family's recollection. "Cases such as these are virtually indefensible

because of the late charting," Douglas says.

In both cases, plaintiff attorneys found out about the late documentation by requesting the audit trail for the EHR during discovery. Time-stamping showed the notes were added or changed after the ED visit.

Altered ED charts also can be discovered when billing records, diagnostic codes, or another provider's notes conflict with the falsified record.

"To prove the EHR chart was falsified, plaintiff's attorneys may use forensic experts to track changes in the EHR," Douglas notes.

Once someone concludes an EP changed the medical record after a bad outcome, the lost credibility is "staggering," according to Douglas. "Such activity is a smoking gun to a jury, especially when the alteration is self-serving to the EP being sued for malpractice."

The EP will not be able to explain it away to the jury, resulting in higher verdicts (and in some states, punitive damages) than would be the case otherwise. "In addition, the EP may face employment termination, regulatory enforcement actions, and criminal charges," Douglas adds.

If there really is a valid reason to correct the EHR, the EP should consult the facility's policies and procedures regarding EHR corrections. If a lawsuit is anticipated or has been filed, consult with legal counsel before adding to previous documentation. Never erase or delete anything from the original record. Instead, use strikethrough text with the original entry still legible. Add an addendum that identifies the late entry or correction. Document the reason for making the correction (such as that the original documentation was in error).

"The EP should avoid extensive defensive notes, or notes that are critical of other providers," Douglas suggests. ■

Added Statement to NPDB Report About ED Lawsuit Is Not Always Warranted

If even one dollar is paid for a malpractice claim, it is going to be reported to the National Practitioner Data Bank (NPDB). Many EPs assume it will immediately ruin their careers.

"In fact, many EPs have NPDB reports. Typically, NPDB reports aren't career-ending," says **Ashley Dobbin Calkins**, JD, an attorney in the Richmond, VA, office of Hancock, Daniel & Johnson.

Malpractice settlements, adverse verdicts, and adverse actions taken by state licensing boards all are reported to the NPDB. "EPs seem to have a general idea that NPDB reports are 'bad,' but aren't sure if it could impact them down the line and, if so, how," Calkins says.

NPDB reports are not available to the general public. However, the information contained in the reports often is publicly available. "Settlements or verdicts and adverse board actions are typically publicly available through state licensing board physician profiles," Calkins notes.

NPDB reports are accessed by potential employers, facilities, and even health insurance companies. These entities often request a detailed explanation of the events leading to the report when considering hiring, credentialing, or recredentialing the EP as a participating provider, according to Calkins.

An excessive number of NPDB reports or a particularly egregious report could make it difficult for an EP to obtain clinical privileges. "Because EPs are hospital-based, an EP who cannot obtain clinical privileges will likewise have a difficult time obtaining employment," says **Jeremy R. Morris**, JD, a partner in the Columbus, OH, office of Bricker & Eckler.

There is no national, state, or local standard applied to hospitals that are evaluating NPDB reports. Instead, each hospital will evaluate physicians who apply for clinical privileges and attempt to ascertain whether that physician meets that particular hospital's standards. "As a result, a physician may be granted clinical privileges at one facility and denied clinical privileges at another, even with substantially similar applications," Morris says.

An EP can add a statement to the report, which remains with the report unless the EP edits or removes it. "In my experience, it's quite rare that a provider statement would be needed or warranted," Calkins shares.

One exception is if an ED malpractice claim was resolved without the EP defendant's consent (because the insurance policy did not require consent to settle). In a case like that, the EP might want to add a statement indicating he or she did not wish to settle and deny any wrongdoing. "This should be professional and succinct," Calkins notes.

The EP should resist the urge to type an angry rant about the case, the judicial system, or insurance companies.

"Anything that comes across as defensive, flippant, or arrogant could cause a lot more problems," Calkins cautions.

The time to consider adding a statement to the NPDB report is "as early as possible," says **Kenneth Alan Totz**, DO, JD, FACEP, a Houston-based attorney and practicing EP. "Yes, it is possible to have a say in what is articulated in the NPDB report."

A good time for this input is when settlement talks have begun or there is a likelihood of an event that will trigger an NPDB report. "This will allow a thoughtful discussion with all parties who may need to agree on the wording of any inclusion," Totz says.

The EP might want to note it was a tiny settlement, or that there were extenuating circumstances. For instance, at the time of a case alleging a delay, the EP might have been caring for multiple intubated COVID-19 patients in a short-staffed ED. "Anyone reviewing the report may consider the mitigating situation," Totz suggests.

A short statement to explain what led to a NPDB report might be acceptable. A lengthy diatribe railing against the injustice of the lawsuit is not. "You're likely to run afoul of HIPAA, and your best intentions will be viewed otherwise by a very cynical public," Totz warns.

Before a physician submits a response to a NPDB report, he or she should seek counsel, Morris advises. In the response, physicians can include any information they believe to be missing from the original report.

"However, the physician must keep in mind that his or her response will be seen by everyone who submits a query," Morris stresses. "Inflammatory statements could do more harm than good." ■

Specific Items, if Well-Documented, Prove ED Met EMTALA Obligations

When CMS surveyors come on site to investigate an EMTALA complaint, the outcome often comes down to documentation.

"EMTALA is one of the biggest concerns when it comes to ED patients and documentation," says **Nathan A. Kottkamp**, JD, a partner at Waller Lansden Dortch & Davis in Nashville. These items in particular can create liability under EMTALA if missing from the ED record:

• When patients transfer to another facility, there must be documentation of the reason why the originating facility lacks the capability and capacity to stabilize those patients. "There should also be documentation about having consulted with the other facility to ensure that it has agreed to the transfer," Kottkamp adds.

"Good" reasons for transfer concern capacity and capability. "Those are the two buzz words for EMTALA purposes," Kottkamp notes. Admission might be the ordinary course of action for a particular patient. "But if the entire hospital is at 100% occupancy due to a COVID outbreak, that would almost certainly justify a transfer," Kottkamp observes.

Even so, some actual details about the situation should be in the record. It might not be enough to simply say something like, "Patient transferred because we are full."

"Indeed, the regulators have been known to look beyond licensed capacity numbers when it comes to being able to serve a surge of patients," Kottkamp recalls.

Other "good" reasons for transfer: Lack of particular equipment necessary for a comprehensive diagnosis, lack of equipment for appropriate treatment, or lack of specialists for the particular situation.

• All ED evaluations should include a physical and psychological component. "Even when a particular injury or condition appears to fall into one category or the other, a dual screening is still required," Kottkamp stresses.

For example, it is unlikely but still possible that a patient with a broken bone caused the injury during a psychological crisis. Similarly, a patient who is exhibiting psychological symptoms could have a complementary physical problem. "It should be clear in the record that the ED physician at least considered psychological issues with respect to the patient," Kottkamp says.

Extensive charting on this point usually is unnecessary. "The record should not, however, be completely silent on the issue," Kottkamp cautions.

It may be a matter of simply describing the patient's demeanor and expressly stating: "Based on the patient's presentation, there was no concern for psychiatric issues, so no formal screening was conducted."

For patients who do present with psychological symptoms, "the documentation ought to be more robust," Kottkamp offers. Depending on the situation, it is highly possible someone with psychological symptoms has engaged in self-harm or risky behavior that resulted in physical injuries.

• When patients are transferred, the ED chart should demonstrate that care and monitoring was provided before the move. "There should not be any extended periods of time where there is no record of any clinician checking in on the patient," Kottkamp underlines.

• If the patient is admitted, the ED chart should reflect the rationale for the decision. "Among other things, the record should reflect the fact that the admission is made in good faith, rather than simply to bypass the obligations of EMTALA," Kottkamp says.

The best way to do this is to describe the plan of care for the inpatient admission and specify a certain room where the patient is headed. "Where possible, indicate the specific name of the admitting physician," Kottkamp adds.

Documentation failures play a part in virtually all EMTALA litigation or settlements, according to **Mary C. Malone**, JD, a partner at Hancock Daniel & Johnson in Richmond, VA. Conversely, good documentation shows surveyors that ED providers were EMTALA-compliant. "The overall process of ensuring that each element of the core EMTALA obligations is documented is crucial," Malone says.

Well-constructed forms, such as consent, refusal, or transfer documents, make this more likely to happen. Prompts in the EHR can help ensure the medical screening exam (MSE) is described in sufficient detail, whether an emergency medical condition is identified, that stabilization is provided, and that the details of the conditions necessitating transfer are documented. "If documentation is not complete at the time of survey, the hospital will likely be subject to an EMTALA violation," Malone warns.

Documentation inadequacies also can be assigned to individual EPs (e.g., failure to perform an appropriate MSE). Both hospitals and clinicians may be subject to monetary penalties for EMTALA infractions. Depending on the circumstances, documentation failures could create the basis for a professional licensure claim, too. "In addition, the lack of documentation can make any associated professional liability claims difficult to defend," Malone adds.

These two cases never resulted in a litigation claim because of excellent documentation:

• A patient was screened for suicide risk after presenting with depression, and was observed in the ED for several hours. Ultimately, the patient was discharged with family members, with a plan in place for outpatient behavioral health treatment. "When the patient committed suicide 236 hours later, the family brought a med/mal suit and filed an EMTALA complaint," Malone reports.

The ED's good documentation showed the patient had been observed, and that stabilizing treatment was provided. This included speaking with the psychiatrist on call, after which the patient left the hospital with family members. There were no signs of any threat to self or others. "The alleged failure to perform a sufficient MSE was not substantiated at survey," Malone says.

• A patient with chest pain decided to leave the ED against medical advice (AMA) before the MSE was completed. The patient would not sign the AMA form. The patient died later that evening of a myocardial infarction.

The family filed an EMTALA complaint and sued for malpractice. The hospital owned great documentation to defend itself. The ED chart noted the portions of the MSE that had been completed, the advice the patient was given not to leave the hospital, and the risks of doing so.

The AMA form was completed with an indication that the patient refused to sign. "Documentation saved the hospital both on the EMTALA complaint and the lawsuit," Malone says. ■

Too Many EP Malpractice Claims Could Mean Liability for Hospital

If patients are constantly suing an EP, the hospital can expect some legal troubles, too. "The problem with bad actors in the ED is simply that they increase the likelihood that the hospital will be dragged into a suit," says **John C. West**, JD, MHA, DFASHRM, CPHRM, principal at West Consulting Services, a Signal Mountain, TN-based risk management and patient safety consulting firm.

In most states, hospitals already are vicariously liable for the actions of their hospital-based physicians,

including EPs. "The vicariously liable hospital lives and dies by the defensibility of the physician claim," West explains.

It is more difficult to defend the care of an EP who is sued constantly. However, in most jurisdictions, the plaintiff has limited ability to delve into a physician's prior claims.

"The plaintiff attorney will certainly have access to them if they were a matter of public record," West says. But he notes the plaintiff attorney has to find them first. "Unpublished decisions, particularly of trial courts, are very difficult to find. Other than the National Practitioner Data Bank, there really is no centralized database of malpractice claims to query."

Even if the plaintiff attorney discovers an EP's prior malpractice lawsuit, it is not necessarily a smoking gun. The general rule is that the plaintiff cannot use previous bad acts to show the defendant acted that same way in the present case. "Exceptions can be made when the defendant places his or her experience at issue in the case," West says.

This can happen if the plaintiff attorney asks about an EP's experience with a certain procedure, and the EP answers that his experience has been good. Then, somehow, the plaintiff attorney discovers the physician's experience consists of 10 successful cases and four unsuccessful cases. "The plaintiff's attorney can then go into detail on the procedures," West adds.

Add-on lawsuits for negligent credentialing are another possible area of exposure for hospitals. However, this is unlikely if the EP is an independent contractor, not a hospital employee.

"Negligent credentialing claims are normally brought against the hospital when the hospital is not vicariously liable for the actions of a medical staff member," West observes.

Vicarious liability normally means the hospital is legally responsible for the actions of the EP. West has never seen allegations against a hospital for negligently credentialing an EP.

"That is not to say they don't happen. But they are exceedingly uncommon," he reports. A negligent credentialing case might be brought if the EP does something for which he or she is not privileged, or acts outside the normal practice of an EP.

Assaulting a patient would fall in this category. "That could happen, but I have never seen such a case," West says. ■

CME/CE QUESTIONS

1. **Which is true regarding social media posts about EDs?**
   a. Posts could be admissible only if directly relating to the ED visit in question.
   b. Social media posts are inadmissible if they include any photographs of ED patients that were posted without permission.
   c. General comments made regarding tort reform posted by expert witnesses would not be admissible, regardless of the timeframe.
   d. Any post made by an ED employee about the department, the hospital, or anything that occurred there could be discoverable as evidence in any lawsuit.

2. **Which is true regarding hospital liability for ED employees claiming retaliation for reporting safety concerns?**
   a. Hospitals have greater legal protection if the decision to terminate or discipline the employee was made by an individual rather than a committee.
   b. Employees should keep stated concerns as general as possible when internally reported to avoid problems with regulatory agencies.
   c. Courts view employers putting an employee on the night shift who did not request this change as clear evidence of retaliation.
   d. Claims of termination because of reporting misconduct in the workplace allow employees to potentially recover more in damages than if the employee was restricted to the workers' compensation system.

3. **In a recent study, which group of ED patients were more likely to have potentially missed appendicitis?**
   a. Men
   b. Patients who experienced abdominal pain accompanied by constipation
   c. Patients without any comorbidities
   d. Patients who underwent CT scans.

4. **Which is true regarding emergency physicians (EPs) and National Practitioner Data Bank (NPDB) reports?**
   a. Settlements less than $10,000 are no longer required to be reported.
   b. All NPDB reports are made available to the general public.
   c. Physicians are reported for adverse verdicts, settlements, and adverse actions taken by state licensing boards.
   d. EPs should add as many exculpatory statements as possible to the NPDB report as they often are helpful to the EP.

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