6 PERSPECTIVES ON EMERGENCY CARE LIABILITY

Special Report presented by Medical Law Perspectives for Healthcare Intelligence Network
6 PERSPECTIVES ON EMERGENCY CARE LIABILITY

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I. EMERGENCY MEDICINE LIABILITY

A. Emergency Department Visits
More than 136 million people visit emergency departments in the United States each year. 45 million visits are related to injuries, with 12 percent resulting in hospital admissions.

Annual Number of Visits to Hospital Emergency Departments: United States, 1995-2005

Trends in Emergency Department Visit Rates by Patient Age: United States, 1995-2005


B. Returns to Emergency Department
The number of patients sent home from emergency rooms in the United States each year who have to return within 72 hours ("bounce backs") because of medical errors has been estimated at between 600,000 to one million. See: Jim Dwyer, Death of a Boy Prompts New Medical Efforts Nationwide, New York Times, Oct 25, 2012. (http://www.nytimes.com/2012/10/26/nyregion/tale-of-rory-staunton-s-death-prompts-new-medical-efforts-nationwide.html?_r=1&)

C. Potential for Hospital Liability
Hospital liability can result when emergency care is not optimal, such as when the emergency room is overcrowded, a delay occurs, complications arise, and mistakes are made. See: Zachary Meisel and Jesse Pines, Waiting Doom: How Hospitals Are Killing ER Patients. Slate, July 24, 2008. (http://www.slate.com/articles/health_and_science/medical Examiner/2008/07/waiting_doom.html)
Increase in Emergency Department Wait Time: 2003 to 2009

- Between 2003 and 2009, mean wait time to see a provider increased 25%, from 46.5 minutes to 58.1 minutes.
- Because wait time is highly skewed, that is, a small percentage (5%) of visits have very long wait times (greater than 3 hours), median wait time is less affected by the skewed distribution and provides an alternative way of describing ED wait time.

Mean and median emergency department wait time to see a provider: U.S., 2003–2009

![Graph showing mean and median wait times from 2003 to 2009](image)

NOTE: Dotted lines represent change in meaning of emergency department wait time. In 2009, emergency department wait time referred to wait time to see a physician, physician assistant, or nurse practitioner; prior to 2009, emergency department wait time referred to wait time to see a physician. SOURCE: CDC/NCHS, National Hospital Ambulatory Medical Care Survey.


Does patient acuity affect wait time for treatment in EDs?

- Two percent of ED patients were triaged as needing to be seen in less than 1 minute (immediate); 10% were triaged as needing to be seen within 1–14 minutes (emergent); 41% were triaged as needing to be seen within 15–60 minutes (urgent); 35% were triaged as needing to be seen within 1–2 hours (semiurgent); and 7% of patients were triaged as needing to be seen between 2 and 24 hours (nonurgent). No triage system was used for the remaining 4% of patients.
Mean wait times for patients triaged as immediate (28.9 minutes) and those with no triage system (38.2 minutes) were shorter than mean wait times for patients triaged as emergent (51.2 minutes), urgent (63.3 minutes), semiurgent (58.7 minutes), and nonurgent (53.5 minutes).

Mean Emergency Department Wait Time for Treatment, by Urgency of Patient Care: U.S., 2009

![Chart showing wait times](chart.png)

1Difference with immediate care is statistically significant ($p < 0.05$).
2Difference with no triage is statistically significant ($p < 0.05$).

SOURCE: CDC/NCHS, National Hospital Ambulatory Medical Care Survey.


Emergency care problems that have been identified include the failure to communicate critical test results, the loss of information in the handoff of the patient’s care, and a diagnosis based on a partial fit with the patient’s symptoms but without serious consideration of alternatives. See: Jim Dwyer, Death of a Boy Prompts New Medical Efforts Nationwide, New York Times, Oct 25, 2012. (http://www.nytimes.com/2012/10/26/nyregion/tale-of-romy-staunton-deaths-prompts-new-medical-efforts-nationwide.html?_r=1&)

Tragic mistakes in the emergency room result in lawsuits. Health management, insurers, risk managers, and others must be aware of the types of lawsuits that may arise and what strategies to employ when an injury occurs in an emergency medical situation.

This report emphasizes the defense aspects of litigation involving emergency care.
D. Theories of Liability
Claims involving injuries in connection with emergency medical treatment may arise under tort, including negligence and intentional torts; under contract; or under statute.

Negligence and Medical Malpractice
Most claims are brought under theories of negligence or medical malpractice. Negligence claims against a physician, or against a hospital for the acts or failures to act of emergency department staff, can include claims for improper treatment; improper diagnosis; delay in treatment; improper supervision of a patient, or of other patients who harm the patient; breach of the applicable medical standard of care; negligent discharge or release; and failure to communicate pertinent medical information regarding the patient. Malpractice cases are listed below. For a complete discussion of the Elements of Malpractice see the full Medical Law Perspectives Report: When Urgency Leads to Errors: Liability for Emergency Care (http://medicallawperspectives.com/IssueView.aspx?Issue=ww_20121205)

Intentional Tort
Intentional tort claims may include assault or battery claims, including claims based on a failure to obtain informed consent, or intentional failure to treat. Intentional tort cases are listed below. For a complete discussion of Intentional Torts see the full Medical Law Perspectives Report: When Urgency Leads to Errors: Liability for Emergency Care (http://medicallawperspectives.com/IssueView.aspx?Issue=ww_20121205)

Vicarious or Other Liability
In some circumstances, hospitals and emergency departments may also be held liable under the doctrines of apparent or ostensible agency or agency by estoppel for the actions and failures of persons who are not actually employees or agents, when the hospital or other entity fosters or permits the appearance of an agency relationship. See generally: Liability of Hospital or Sanitarium for Negligence of Independent Physician or Surgeon--Exception Where Physician Has Ostensible Agency or "Agency by Estoppel," 64 A.L.R.6th 249.

Breach of Contract
Breach of contract claims, while rare in situations involving emergency medical treatment, sometimes arise in situations involving managed care providers or hospitals.

See generally: Liability of Hospital or Other Emergency Room Service Provider For Injury To Patient or Visitor, 67 Am. Jur. Trials 271, § 138; Hospital liability as to diagnosis and care of patients in emergency room, 58 A.L.R.5th 613.

Statutory Violation
A patient may have a claim in some circumstances for a breach of a statutory duty, such as a claim under the Emergency Medical Treatment and Active Labor Act, 42 U.S.C.A. § 1395dd (EMTALA). Hospitals and emergency departments may be liable for the actions
and failures of their employees and agents under the theory of respondeat superior. See generally: Liability of Hospital or Other Emergency Room Service Provider For Injury To Patient or Visitor, 67 Am. Jur. Trials 271; Hospital liability as to diagnosis and care of patients in emergency room, 58 A.L.R.5th 613; Establishing Hospital Liability under the Emergency Medical Treatment and Active Labor Act for "Patient Dumping." 62 Am. Jur. Trials 119.

Important hospital and emergency department liability cases are listed below. For a complete discussion of hospital and emergency department liability see the full Medical Law Perspectives Report: When Urgency Leads to Errors: Liability for Emergency Care (http://medicallawperspectives.com/IssueView.aspx?Issue=ww_20121205)

Important Cases

Important Malpractice Cases

The alleged negligence must be shown to be the proximate cause of the patient’s injury. Where a patient's widower brought a medical malpractice action against a hospital, alleging that the emergency room physician failed to give the patient sufficient discharge instructions concerning avoidance of deep vein thrombosis, the court found that the widower had failed to show that the absence of a specific discharge instruction was the proximate cause of the patient’s development of a blood clot that dislodged, traveled to the heart, and caused sudden death. The widower failed to show that the injury more likely than not resulted from the physician’s alleged negligence in failing to instruct the patient to try to be as mobile as possible. See: Guadagno v. Lifemark Hospitals of Florida, Inc., 972 So.2d 214 (Fla.App. 3 Dist., Dec 05, 2007).

In a medical malpractice action against an emergency room physician for failing to diagnose a heart attack, instructions to the jury that the jurors should compare the physician's actions to that of a prudent physician similarly situated under the same or similar circumstances were adequate, but a better practice would have been to instruct the jury that, in evaluating the physician’s conduct, the jury should compare the physician's actions to those of a doctor in the same field of medicine. See: Daves v. Cleary, 584 S.E.2d 423 (S.C.App., Jun 16, 2003), rehearing denied (Aug 22, 2003), certiorari denied (Jul 22, 2004).

Delay in providing care can amount to a breach of the standard of care in an emergency medical situation. See: Robinson v. Adirondack Medical Center, 244 F.Supp.2d 66 (N.D.N.Y., Feb 07, 2003).

Discharge instructions were not found to be inadequate, and did not breach the standard of care, where the physician supplemented the written discharge instructions with additional verbal discharge instructions. See: Clelland v. Haas, 774 So.2d 1243 (La.App. 1 Cir. Dec 22, 2000).
After establishing the standard of care, counsel for the patient must also be able to demonstrate that the defendant’s conduct deviated from the established standard. In this case, the physician exhibited the skill and knowledge possessed by emergency room physicians in his treatment of the patient who died of a sudden, unpredictable event. See: *Snia v. United Medical Center of New Orleans*, 637 So.2d 1290 (La.App. 4 Cir., May 26, 1994), writ denied, 644 So.2d 637 (La. Oct 07, 1994).


**Important Intentional Tort Cases**

The doctrine of implied consent protected a hospital, physician, and other medical personnel in a medical battery action involving a patient whose blood and urine were forcibly withdrawn, in an attempt to determine the existence of a potentially fatal drug interaction or overdose. When a medical emergency exists, if the patient is in an impaired state rendering the patient incapable of refusing to consent to medical treatment, the emergency exception to the informed consent rule applies. This rule extends to virtually any medical procedure necessary to preserve the life or health of the patient. See: *In re Estate of Allen*, 365 Ill.App.3d 378, 848 N.E.2d 202, 302 Ill.Dec. 202 (Ill.App. 2 Dist. May 02, 2006).

Even in an emergency situation, however, a competent patient has the right to refuse treatment. If the patient does refuse treatment, any medical treatment is a battery. A battery claim, while requiring proof of causation and damages, does not require proof of duty and breach of that duty, but rather proof of an intentional touching without consent. See: *Anderson v. St. Francis-St. George Hosp.*, 83 Ohio App.3d 221, 614 N.E.2d 841 (Ohio App. 1 Dist. Nov 18, 1992), judgment rev’d on other grounds, *Anderson v. St. Francis-St. George Hosp., Inc.*, 77 Ohio St.3d 82 (Ohio Oct 10, 1996).

Lawsuits involving intentional torts such as assault and/or battery may involve the negligence or breach of duty of a hospital that fails to protect one patient from an intentional tort committed by another patient. For example, a hospital was found liable for injuries sustained by a patient who was raped by another patient while she was in multiple restraints and unsupervised in an emergency room. See: *Freeman v. St. Clare's Hosp. & Health Center*, 156 A.D.2d 300, 548 N.Y.S.2d 686 (N.Y.A.D. 1 Dept., Dec 21, 1989).

**Important Vicarious and Other Liability Cases**

Even where a hospital does not expressly hold out its emergency room doctors as employees or agents, an agency relationship can be inferred from circumstantial evidence, such as the hospital holding itself out to the public as maintaining a 24-hour emergency room, without taking any “affirmative steps to combat the natural assumption that the emergency room doctors were hospital employees,” and billing for the services
performed by the emergency room doctors. See: Wilkins v. Marshalltown Medical and Surgical Center, 758 N.W.2d 232 (Iowa, Dec 5, 2008).

A patient who visited a hospital emergency room experiencing back pain and unable to move his right leg or to walk was able to state a claim against the hospital under EMTALA for failing to provide the patient with an appropriate medical screening examination and for failing to stabilize his medical condition before discharging him. The hospital performed a CT scan of the patient’s spine and discharged him with orders to visit an orthopedist the next day. See: Stowe v. Russell, 564 F.Supp.2d 666 (E.D.Tex., Mar 24, 2008).

In an emergency room setting, when the patient may have entered the hospital through the emergency room and sought treatment from the hospital, rather than from a particular physician, a hospital may be found liable for the negligence of an independent contractor physician. See: Ryan v. New York City Health and Hospitals Corp., 220 A.D.2d 734, 633 N.Y.S.2d 500 (N.Y.A.D. 2 Dept., Oct 30, 1995).

See also: Salvatore v. Winthrop University Medical Center, 36 A.D.3d 887, 829 N.Y.S.2d 183 (N.Y.A.D. 2 Dept., Jan 30, 2007) (the patient was brought to the hospital's emergency room after he was struck by a car, and the hospital directed the non-employee physician to examine the patient and render treatment).

See also: Johnson v. Jamaica Hosp. Medical Center, 21 A.D.3d 881, 800 N.Y.S.2d 609 (N.Y.A.D. 2 Dept., Sep 6, 2005) (the patient visited the hospital on an emergency basis, and did not request treatment by any particular physician, and was treated by a non-employee doctor).

E. Defenses

Good Samaritan

The legislative purpose behind the Good Samaritan statutes, as applied to physicians, is to encourage physicians to provide medical assistance to persons in need of emergency medical care. This statutory purpose is best served by discouraging even the commencement of an action against a health care professional who has provided emergency medical assistance. See: Reynoso v. Newman, 126 Cal.App.4th 494, 24 Cal.Rptr.3d 5 (Cal.App. 4 Dist., Jan 10, 2005).

A doctor, who had responded to a dentist's call for assistance after the dentist’s patient began spitting up blood following oral surgery, was immune from liability for negligence under the California “Good Samaritan” statutes. In the court’s view, it was undisputed that an emergency existed when the doctor volunteered to treat the patient, and the doctor's subjective belief as to whether he was responding to an actual emergency was irrelevant. See: Reynoso v. Newman, 126 Cal.App.4th 494, 24 Cal.Rptr.3d 5 (Cal.App. 4 Dist., Jan 10, 2005).
Sudden Emergency

The sudden emergency doctrine may be used as a defense to medical malpractice, even in an action involving emergency medical treatment. See generally: *Malpractice by Emergency Department Physician*, 47 Am. Jur. Proof of Facts 2d §15.3. This doctrine generally provides that if a person, without negligence on his or her part, is confronted with a sudden emergency, the person is not to be held to the same standard of conduct normally applied to a person who is not in an emergency situation. See generally: 57A Am. Jur. 2d Negligence § 198, *Sudden-emergency doctrine, generally*.

For example, an emergency physician treating a patient for a cut finger was confronted by a sudden emergency when the patient experienced a vasovagal reaction, accompanied by a fainting episode and jerking movements that resembled seizures, leading to the patient’s fall from a gurney despite the physician’s efforts to protect the patient from falling. The court disagreed with the patient’s argument that the sudden emergency doctrine does not apply in a medical malpractice case to lower the standard of acceptable professional practice required of an emergency room physician. It found that, even though a physician may be practicing in emergency medicine, that practice does not necessarily involve sudden and unexpected circumstances leaving no room for thought, deliberation, or consideration. See: *Ross v. Vanderbilt University Medical Center*, 27 S.W.3d 523 (Tenn.Ct.App. Feb 18, 2000), appeal denied (Sep 11, 2000).

II. UNDERSTANDING THE MEDICAL ASPECTS OF EMERGENCY CARE

It is critical for the hospital-employer and risk manager, the insurer, the physician and health provider, defense counsel, and the plaintiff’s attorney to understand emergency health care. Below is detailed medical information on emergency and trauma care, providers and staffing, emergency record contents, and care controls.

A. Emergency Care, In General

Emergency health care services are available at hospitals and other health facilities. Most hospitals provide emergency departments. However, some hospitals and other types of health care facilities have decided to eliminate emergency services. Patient health care concerns that are not emergent are referred out of the emergency department. See 1 Attorneys Medical Deskbook § 8:8, Emergency department. Also, the Trauma Committee of the American College of Surgeons has prescribed the requirements for three levels of trauma centers. Despite differences in detail, Level I and Level II are similar in that both levels have a surgeon and an anesthesiologist in-house 24 hours a day who are prepared to give immediate maximal care to an injured trauma patient. A Level III center, in distinction, is capable of stabilizing the injured patient and transporting him to a Level I or Level II center. A trauma center has specific personnel requirements with staffing that includes experienced general surgeons, neurosurgeons, surgical specialists, emergency physicians, nonsurgical specialists, and specially trained nurses and support personnel. Also, specialized equipment is used. See: 4 Attorneys Medical Advisor § 33:8, 33:9, 33:10, Regional Trauma Center.

“By its nature, a modern Emergency Department is particularly vulnerable to malpractice situations. The Emergency Department physician is faced with a variety of acute medical and traumatic problems crossing a broad spectrum of medical specialties, an unpredictable work load, a routine of medical crisis situations, and patients presenting without the benefit of a long-term medical relationship upon which the physician may draw to evaluate the individual patient's symptoms.” See: Malpractice By Emergency Department Physician, 47 Am. Jur. Proof of Facts 2d 1.

Ten Most Frequent Complaints in Acute Care Visits, By Setting, 2001-2004

<table>
<thead>
<tr>
<th>Setting of care/complaint</th>
<th>Percent (standard error)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency department total</td>
<td>33.6 (0.6)</td>
</tr>
<tr>
<td>Stomach and abdominal pain</td>
<td>6.6</td>
</tr>
<tr>
<td>Chest pain and related symptoms</td>
<td>5.3</td>
</tr>
<tr>
<td>Fever</td>
<td>4.6</td>
</tr>
<tr>
<td>Cough</td>
<td>2.9</td>
</tr>
<tr>
<td>Headache, pain in head</td>
<td>2.7</td>
</tr>
<tr>
<td>Symptom</td>
<td>Percentage</td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>------------</td>
</tr>
<tr>
<td>Shortness of breath</td>
<td>2.5</td>
</tr>
<tr>
<td>Back symptoms</td>
<td>2.4</td>
</tr>
<tr>
<td>Vomiting</td>
<td>2.2</td>
</tr>
<tr>
<td>Symptoms referable to throat</td>
<td>2.2</td>
</tr>
<tr>
<td>Pain, nonspecific</td>
<td>2.1</td>
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<tr>
<td><strong>General/family practice total</strong></td>
<td><strong>37.0 (0.9)</strong></td>
</tr>
<tr>
<td>Cough</td>
<td>8.0</td>
</tr>
<tr>
<td>Symptoms referable to throat</td>
<td>6.6</td>
</tr>
<tr>
<td>Skin rash</td>
<td>3.1</td>
</tr>
<tr>
<td>Earache or ear infection</td>
<td>3.1</td>
</tr>
<tr>
<td>Head cold, upper respiratory infection</td>
<td>2.9</td>
</tr>
<tr>
<td>Stomach and abdominal pain</td>
<td>2.9</td>
</tr>
<tr>
<td>Sinus problems</td>
<td>2.7</td>
</tr>
<tr>
<td>Nasal congestion</td>
<td>2.6</td>
</tr>
<tr>
<td>Back symptoms</td>
<td>2.5</td>
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<tr>
<td>Fever</td>
<td>2.5</td>
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<tr>
<td><strong>Non-primary care specialty total</strong></td>
<td><strong>23.5 (0.7)</strong></td>
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<tr>
<td>Vision dysfunctions</td>
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<tr>
<td>Knee symptoms</td>
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<tr>
<td>Stomach and abdominal pain</td>
<td>2.6</td>
</tr>
<tr>
<td>Hand and finger symptoms</td>
<td>2.4</td>
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<tr>
<td>Skin rash</td>
<td>2.3</td>
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<tr>
<td>Shoulder symptoms</td>
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</tr>
<tr>
<td>Counseling NOS</td>
<td>1.8</td>
</tr>
<tr>
<td>Discoloration or pigmentation</td>
<td>1.7</td>
</tr>
<tr>
<td>Abnormal sensations of the eye</td>
<td>1.7</td>
</tr>
<tr>
<td>Cough</td>
<td>1.6</td>
</tr>
</tbody>
</table>

B. Emergency Departments, Generally
Emergency departments usually consist of a suite of rooms equipped for the treatment of emergency problems. One or more rooms are designated for life-threatening emergencies, and contain a cardiac monitor along with other resuscitation equipment. 1 Attorneys Medical Deskbook § 8:8, Emergency department.

C. Maintenance of Emergency Care Medical Records
Maintaining complete and accurate emergency care records is very important. Generally, emergency records contain:

1. Some statement of the patient's history made to an emergency department nurse or clerk.
2. The findings, opinions, and treatment of the emergency physician.
3. Observations and actions by the emergency department nurses.

However, emergency department records vary considerably in content depending on the usual practices of the emergency department physician and the policies of the facility. See: 1 Attorneys Medical Deskbook § 2:17, Emergency records.

Emergency records may be included with the hospital in-patient records, or may be kept separately. Emergency records may be stored for a period of time in the emergency department rather than in the medical records department of the hospital. Emergency records should always be expressly requested from the specific area in which these records are located in a health facility by the attorney when seeking medical records. See: 1 Attorneys Medical Deskbook § 2:17, Emergency records.

Some parts of an emergency record are not generated and added to the record until days after the visit, and therefore may not be included with an emergency record that is requested immediately following an incident. These parts may include specialty consultation reports, reports of laboratory studies, and radiologists' reports of imaging studies. See: 1 Attorneys Medical Deskbook § 2:17, Emergency records.

D. Guidelines for Hospital Emergency Care
Each hospital emergency department has rules and regulations that must be complied with when providing emergency care. These rules and regulations generally define the standard that the hospital expects its employees and those operating with staff privileges to follow. This self-declared standard may include specific requirements that all persons presenting with emergency conditions must be treated and stabilized prior to terminating medical care, or that a patient may not be discharged from the emergency department or refused admission without being seen by a physician.
Typically, each health facility's rules provide procedures for summoning on-call or specialist physicians, requesting laboratory procedures, and similar requirements that apply when a patient is seen and treated in the emergency department.

The leading standard that are adopted by hospitals across the country have been those established by the Joint Commission on Accreditation of Hospitals (JCAH), which each hospital must meet to become accredited. See: *Malpractice By Emergency Department Physician*, 47 Am. Jur. Proof of Facts 2d 1.

**E. Patient Care in Hospital Emergency Departments**
The following illustrates a typical emergency department patient visit:

1. Brief evaluation of the patient's condition by a triage nurse to determine the urgency of being seen by a physician. The patient may be designated as non-urgent and sent to wait until all urgent care patients are handled.

2. Interview by a clerk to record the reason for the visit, insurance coverage, patient background such as address and date of birth, name of attending physician, family contacts, method of arrival at the emergency department, time of arrival, etc. This information generally appears in an emergency department cover sheet.

3. Vital signs are taken by a nurse or nursing assistant, including blood pressure, pulse, respiratory rate and temperature. Vital signs may also include pulse oximetry readings indicating oxygen saturation of the blood expressed in a percent. Normal numbers for pulse oximetry readings should be in the high nineties. Lower numbers indicate reduced levels of oxygen in the bloodstream.

4. Patient history directed at the specific reason for the visit. Other aspects of the patient's history are usually omitted. This history typically includes:
   
   a. The symptoms or injuries that are the reason for the visit. For example, “shortness of breath” or “struck head on floor and had one minute loss of consciousness.” Symptoms of other conditions that do not relate directly to the reason for the visit will not be identified.

   b. Any prior history that may relate to the reason for the visit. For example, history of childhood asthma or history of myocardial infarction three years ago.

   c. Current medications, including both prescription and non-prescription medications.

   d. Clinicians being seen for related medical problems.

5. A physical examination directed at the specific reason for the visit and the specific organ system involved. For example, a careful neurological examination may be necessary following a head injury. In this case, there may be no action taken considering
the cardiovascular system. In comparison, an emergency visit for chest pain usually would have no neurological examination.

6. A differential diagnosis is made and recorded in the emergency records. For example, “Assessment: viral gastroenteritis, R/O food poisoning, R/O appendicitis, R/O bowel obstruction.” If a “R/O” (rule out) diagnosis would constitute an emergency, some diagnostic measure is required to exclude it as a diagnosis in that case.

7. Procedures may be done in the emergency department such as infusing IV fluids, suturing a laceration, or similar procedures. Or, the patient may be taken to other hospital areas in a wheelchair or on a gurney, for example to obtain a CT Scan or electrocardiogram. These procedures are recorded by the physician, nurses, or nursing assistants.

8. Laboratory studies may be ordered, typically with samples obtained in the emergency department. For example, CBC, urinalysis, blood culture, liver function studies, cardiac enzymes, etc. Some of those laboratory test reports may not be back and seen by the emergency physician until days after the emergency visit. The date listed for the collection or completion of the laboratory study may be the same as the date of the emergency visit, but the actual printed report may not have been back. This means the emergency diagnosis was not based on that laboratory result. Sometimes the laboratory test result is immediately called to the emergency physician. If this is done, it will say so either on the laboratory report or on the emergency physician's progress record.

9. Emergency imaging studies such as x-ray, CT or MRI may be performed. These are often performed outside the emergency department. Usually, the emergency physician will initially read these imaging studies and base diagnostic conclusions on the readings during the emergency visit. Radiologists are better qualified to interpret imaging studies. Therefore, a radiologist will also read the studies, but sometimes not until days later. Ordinarily, the radiologist's report will not be available to the emergency doctor until after the patient is discharged.

10. Medications may be administered in the emergency department. These are usually administered and recorded by nurses or nursing assistants at the direction of the physician.

11. While the patient is in the emergency department, the patient should be monitored. For example, “neurological function unchanged” may be recorded at regular intervals over a course of several hours. Monitoring is often recorded by nurses or nursing assistants.

12. Requests for emergency specialty consultations made while the patient is in the emergency department. For example, a pediatric surgeon may consult regarding the need for surgery for an injured child. These specialty consultations obtained during the emergency visit may be recorded either directly in the emergency department progress
record at the time, or as a separate “Consultation Report” attached to the emergency
department record.

13. Disposition or discharge of the patient occurs. This may include:
   a. Transfer for in-patient hospitalization.
   b. Discharge to home with medications or prescriptions.
   c. Patient treated and follow-up visit with attending physician or consultant
      scheduled.
   d. Transfer to a different hospital, usually where the transferring hospital lacks the
      facilities or staff to safely treat the patient's condition.
   e. Where the diagnosis was not an emergency, patients may be sent home untreated
      with instructions to make appointments to see their regular physicians or with a
      short-term prescription, such as an antibiotic. This may occur with indigent patients
      who do not have health insurance and who may use emergency services in place of
      regular medical care.

14. Discharge instructions are provided to patients who are sent home. These may include
   both verbal instructions and standardized pre-printed forms provided to the patient such
   as head injury precautions or diet instructions.

15. The date and time of discharge are recorded.

16. The names of the emergency physician and nurse are included in the records.

17. A form may also be generated if the patient is to be transferred to a different hospital.
   This form is designed to prove that the requirements were met under federal law.
   The Emergency Medical Treatment and Labor Act, or EMTLA (part of the Consolidated
   Omnibus Budget Reconciliation Act of 1985 (COBRA), Pub. L. 99-272) is also known as
   the “anti-dumping” law. The form may include:
   a. The patient's consent to the transfer.
   b. Reasons for the transfer.
   c. Certification that the patient's emergency condition is stabilized.
   d. The name of the receiving facility.
   e. The name of the person at the receiving facility who agreed to the transfer.
f. That copies of the medical records will be sent with the patient.

g. That the patient will be transported by qualified personnel.

See: 1 Attorneys Medical Deskbook § 2:17, Emergency records.

F. Emergency Care of the Trauma Patient

Emergency care of trauma patients generally includes trauma in three different classes of life-threatening injuries: (1) Immediately fatal injury such as severe brain injury or rupture of the heart or major artery. These injuries cause death so quickly that effective treatment is impossible in most cases. (2) Death within an hour of injury, which may be preventable or treatable if appropriate measures are taken in a timely manner. Two common examples of this type of injury are tension pneumothorax and cardiac tamponade, both of which are conditions causing compression of the heart, arising from chest injuries. (3) Complication injury, injuries and organ failures occurring hours or days after the original trauma. Common examples of these injuries, are sepsis (infection), shock, and “multiple organ failure” (MOF). See: 4 Attorneys Medical Advisor §§ 33:24 to 33:31, Emergency Care of Trauma Patients.

The following is a listing of the proper sequence of procedures to provide emergency care to a trauma victim (such as a person in an automobile accident who suffers multiple injuries):

- Establish airway and ventilation (with control of cervical spine to avoid causing or exacerbating spinal injuries)

- Maintain adequate perfusion (normal blood flow to all tissues)

- Control hemorrhages

- Assess and correct neurological abnormalities

- Stabilize fractures

- Perform a detailed systematic assessment

See: 4 Attorneys Medical Advisor § 33:24, Emergency Care of Trauma Patients-Overview.

G. Emergency Department Staff

The staffing of large emergency departments is by house staff (residents) or by salaried emergency physicians. In many hospitals, these physicians are employed by an emergency physician staffing group under contract with the hospital. The emergency department staff usually call for assistance from specialists when complex emergency problems are encountered. The specialists may be residents on call in the hospital. See 1 Attorneys Medical Deskbook § 8:8, Emergency department.
In addition to emergency care physicians, well-trained emergency department nurses are indispensable in critical situations. Furthermore, they often provide training and valuable advice to receptive residents. Additional emergency department assistance may come from a paramedical specialist called the Emergency Medical Service Technician. See: 1 Attorneys Medical Deskbook § 8:8, *Emergency department*.

Small emergency departments may be staffed only by a nurse who must call a physician from elsewhere in the hospital when necessary. That physician may be required to deal with problems of hospital patients, and may not always be able to come when needed. This can result in dangerous delays. See: 1 Attorneys Medical Deskbook § 8:8, *Emergency department*.

III. EXPERT GUIDANCE: Charles R. Grassie, MD, JD; James Bartimus, JD

Charles R. Grassie, M.D., J.D.
Chairman of the Medical Legal Committee, American College of Emergency Physicians

What Steps Can Emergency Physicians Take To Avoid Liability When Providing Care?

How much liability an emergency room doctor experiences in a career is a function of the venue in which the doctor is working. There are high risk venues and low risk venues. On average, an ER doctor will get sued once every four or five years. Virtually every emergency physician in this country gets sued eventually, no matter where they work. There are many things other than work venue shopping that an emergency physician can do to minimize risk of suit. We all know physicians who never seem to get sued and, vice versa, some very good physicians who seem to get sued a lot. Some of that disparity is perhaps the randomness of lightning strikes, but a lot of it has to do with basic interpersonal skills. A lawsuit is just the ultimate patient complaint. Very simple things, such as body language, how you approach the patient, listening to the patient, make a huge difference in terms of the patient forgiving any sins that might have occurred. Emergency physicians are at a disadvantage compared to family practitioners in that respect, but it still has a major impact on a patient, and therefore on your risk of suit, when you can develop a rapport quickly.

Other things emergency physicians can do involve specific responses to specific patient complaints. Yes, substantive medical care! About one third of our indemnity dollars go to missed myocardial infarctions (MIs), or missed heart attacks, and so any chest pain should be treated very cautiously. Chest pain units, which are now available in many emergency departments, are extremely beneficial. I would never be in a rush to send a chest pain patient home.

Another diagnosis that has reared its head recently, at least in the last 10 to 15 years, with large dollar value if not large frequency, is cauda equina syndrome. We frequently see patients with chronic back pain and, as a consequence, they’ll often receive rude and abbreviated care in the emergency department because many ED practitioners feel offended by patients the providers perceive as drug-seeking. These are the very patients that are often at risk of a more catastrophic presentation and their experience in the ED may have been one hateful encounter after another. But they may be like “The Boy Who Cried Wolf.” If you just ask and document, every time a back patient comes in, whether or not they have incontinence of urine or stool, then you have established a defense
against a missed diagnosis of cauda equina, which could be a major lawsuit. If the problem develops subsequent to the ED visit, you can show that you considered it and it wasn’t there at the time of the visit. Even if you just saw that patient an hour before and discharged them, ask again – you just got a second chance to pull it out of the fire.

Another increasingly frequent lawsuit coming down the pipe involves transient ischemic attacks, or TIAs, which are sometimes called “mini-strokes” or “warning strokes.” Many patients with TIAs still get sent home after they’ve recovered. Because of all the publicity around thrombolytics and strokes, patients and their attorneys expect miracles. What you can do to minimize the risk of a lawsuit involving a TIA is to just put under observation all of the TIA patients that come in, so that the workup can be completed before they leave and, if the stroke progresses, a rapid intervention can take place. I won’t touch on the controversy regarding thrombolytics and strokes because it is a hot evolving area and there are many on both sides of the question. While we see more suits for failure to give thrombolytics in stroke, we also see many for giving it!

Lawsuits are brutally painful for most physicians, ER or otherwise. I have personally known four physicians who committed suicide on the heels of a malpractice suit. For a physician facing a malpractice suit it’s extremely important that you obey your attorney and don’t talk to anyone – especially anyone involved with the case, which would look too much like collusion or getting your stories straight. But, on the other hand, it’s also important that you get help to see you through the problem. Keep in mind that we are human; we make mistakes. You have to forgive yourself for that. And remember that every mistake is not malpractice. The law doesn’t expect you to be perfect; it expects you to practice “ordinary care” – to do what the usual physician under the same or similar circumstances would do.

Dr. Charles R. Grassie is both a physician and an attorney. He is board-certified in emergency medicine, a Fellow of the American College of Emergency Physicians, and admitted to the bar in Michigan.

Dr. Grassie was formerly the President and CEO of Emergency Physicians Medical Group, Ann Arbor, MI, and is currently a member of the board of directors of and consultant to the Emergency Physicians Medical Group. He has served on the board of directors of four different medical malpractice insurance companies. He serves as the Chairman of the Medical Legal Committee of the American College of Emergency Physicians. (http://www.acep.org/)

Dr. Grassie received his M.D. from the Washington University School of Medicine in St. Louis, Missouri and his J.D. from the University of Michigan Law School in Ann Arbor, Michigan.
What Guidance Should Attorneys Consider When Facing the Challenges of Emergency Medical Malpractice Litigation?

Any lawyer who is considering undertaking a medical negligence case that involves emergency medicine should understand the background and nature of emergency medicine, including how and when it became a specialty area. About 20% of all claims occurring in a hospital happen in the emergency department. It’s the third riskiest area of the hospital outside of the operating room and the labor and delivery suite. The claims are usually significant, involving significant medical and economic damages. Examples include missed ectopic pregnancies, appendicitis, meningitis, missed fractures, soft tissue injuries, and foreign bodies. Anyone considering taking on an emergency department or emergency physician case needs to understand that those doctors have to have a very broad range of information about what they do. In fact, the three biggest areas of claims involve the physician’s information gathering, decision making, and supervision of pre-hospital personnel.

As in any negligence case, the plaintiff has the burden of proving the four basic elements, including the duty of care. For an emergency physician that duty can start outside of the emergency room. Isolating the moment that paramedics come under medical control is often pivotal. When did the EMS make contact? What did the telemetry show; did the physician review it? In cardiac cases this is a critical issue. What did the emergency physician order for this patient he’s likely never seen, based on the medic’s report and telemetry? An emergency doctor is held to a standard of care promulgated primarily by the American College of Emergency Physicians (ACEP). It’s a great source to determine whether somebody dropped the ball.

In addition to the clinical guidelines published by the American College of Emergency Physicians, the organization has other resources including symposiums, practice resources, and continuing education. Lawyers handling emergency cases need to have this guidance to meet the challenges of trying to take on an emergency physician’s case. They need to know the background of a particular physician, where they were trained, what additional continuing medical education they had, whether they were up on the latest information that was put out for a particular condition, whether they were aware of the publications sent by the National Institutes of Health to all emergency rooms in the United States. Were those publications posted in the hospital?

Examine the physician’s background. What skills, residencies, and credentials do they need? A physician who is board-certified by the American College of Emergency Physicians has met their exacting standards and is likely familiar with the ACEP
protocols. The Joint Commission (formerly the Joint Commission on Accreditation of Healthcare Organizations) is the certifying body for hospitals providing services billed to Medicaid or Medicare. Under its standards any physician working in the emergency room is held to the same standard as a board-certified emergency physician. Yet rural hospitals are often covered by non-credentialed (moonlighting) internists or family medicine doctors. These physicians often are not aware of the ACEP standards.

The ACEP clinical guidelines (available on their website) are a good starting point to determine whether the physician met the standard of care. The standards are pretty clear as to what information doctors need to gather and what decisions they should make in defined circumstances. But they are only the starting point. Emergency physicians also need to be familiar with the American Academy of Pediatrics standards for infant and pediatric resuscitation and the Advanced Cardiac Life Support (ACLS) standards of the American Heart Association. These entities have their own algorithms and methodologies for resuscitative efforts as well as what should or should not be done. The American College of Physicians is another point of reference for clinical standards that doctors need to meet in the emergency room.

Causation is always a hurdle. Some emergency brought the patient into the emergency room, and it is necessary to separate out the injuries and damages that flow from the negligence from the injuries that caused the visit in the first place. While most people don’t go to the emergency room unless they have a significant problem, some uninsured patients use the emergency room for primary care.

In emergency room liability, whether a delay in diagnosis or treatment occurred is often a critical question. Delay itself may help to establish negligence. Today, because overcrowding in the emergency room is worse than it’s ever been, delays are getting longer and longer, so whether triage was performed appropriately in the emergency room is often the first consideration in evaluating liability. What else was happening in the emergency room at the time? Should the patient have been diverted to another emergency room by the ambulance at the instruction of the physicians? It is a challenge for the attorney to learn exactly what communications took place. Often emergency communications are recorded, but tapes are sometimes kept for very short periods.

Did the physician employ appropriate diagnostics? For example, should the patient have been diagnosed properly as a pending myocardial infarction, but instead was diagnosed with gastroenteritis without sufficient testing? Was the patient’s shortness of breath written off to pneumonia when appropriate testing would have revealed a pulmonary embolus?

Was there a failure to obtain appropriate consults? There are limits to an emergency physician’s expertise. The emergency physician is a gatekeeper and has a duty to involve specialists like neurosurgeons and pulmonologists when clinical problems go beyond his expertise.
Failure to diagnose leads to failure to treat. If the physician fails to employ a consultant pediatrician and misses meningitis, he will not initiate proper treatment. If the physician fails to gather sufficient history and perform appropriate diagnostic studies, the gastroenteritis left untreated becomes a myocardial infarction and sudden death. The failure to consult a surgeon when the patient presents with an acute abdomen leads to failure to treat appendicitis. All of these failures to treat arise from a failure to gather appropriate information and make appropriate decisions.

Just as technology has solved many problems in medicine, so too has it created some. Radiologists in distant cities may be asked to read radiographs sent electronically to them for analysis. Before these internet-based services ER physicians would often read films themselves. Today, with these “night hawking” radiologists, many of these x-rays are reported back to the ER physician on a “stat” basis. The emergency room physician still has an obligation to read over that report and make sense of it based on the clinical presentation of the patient. The challenge for case presentation is that the emergency physician may not be held to the same standards as the radiologist, but the radiologist is not touching or seeing that patient and may not even be in the same state as the patient. So the emergency physician has a responsibility to correlate the clinical findings with the radiology findings and reach an appropriate diagnosis.

The most common life-threatening emergencies involve cardiovascular, pulmonary, orthopedic, traumatic and pediatric patients. An ER physician has to be particularly knowledgeable in these areas, knowing both what he knows, and what he does not know. The corresponding challenge for the attorney is to evaluate the training of the physician in the context of the case. What resources did the emergency department have available to the physician? Most have materials, including the internet, immediately available to physicians so that they can look up any algorithms. The lawyer proceeding against the physician must look at what was – or should have been – available, including the Physician’s Desk Reference or PDR and the policies and procedures of the hospital. What do these resources say about the duty to consult, how quickly physicians need to have orders in, and what diagnostic priorities are? Also keep in mind that at least one issue may be the capability of that hospital. Does it have a CT scanner? Many 50 bed facilities do not. What are the policies and procedures promulgated by professional organizations that are available to physicians to help them determine whether or not they or on the right diagnostic track? For example, the American Heart Association says “time is muscle” in heart attacks, and it has promulgated standards and algorithms showing physicians what steps they should employ in what order.

Attorneys must understand the process of differential diagnosis and how life-threatening causes are ruled out first. Maybe it seems reasonable on first blush that the doctor was thinking about heartburn instead of pulmonary embolism. The lawyer needs to have an understanding of how a physician should have sorted that out – what steps should have been taken to limit the differential diagnosis so that the physician is actually making an accurate diagnosis as opposed to a reasonable but incorrect diagnosis.
Triage, the first step inside the ER, should not be overlooked in cases of delay and misdiagnosis. Did the physicians see the patient? When did the physician see the patient? What information or communication did the physician have? Electronic medical records can both improve patient care and obfuscate what a physician actually relied on. While the medical record is electronically kept down to specifics in seconds, and you know exactly when an entry was made, you may lack contemporaneous recording of a physician’s analysis and thought process, because physicians may rely on others to record information they previously wrote down in their progress notes. On the other hand, you rarely have to guess about signatures as you sometimes do with paper records. Electronic medical records also may improve access to old medical records and prior ER visits. This is particularly useful in analyzing cases where a physician failed to interdict child abuse. Yet, not all records flow seamlessly into the electronic medical record. Hand-written run reports from EMS and transcripts of telemetry and other data may not be electronically available until after the patient is discharged and the records are scanned.

Post-hospital discharge represents another major consideration for the attorney. What was the patient told when they left? What orders were written down? Were the orders from the discharge nurse different than what the physician was telling the patient? Was the medication that was written down legible? Were they told when to take the medication and how to take it? What follow-up were they given for this particular condition? At least one of every four patients coming into the emergency room had a recent prior emergency room visit. What took place at that visit (particularly if it was at the same hospital)? Were those records pulled up for comparison?

Did the physician spend an appropriate amount of time gathering and analyzing clinical data? How much time did the emergency physician actually spend bedside with this patient? What else was going on that night? How full was the emergency room? Did the emergency room physician call for a back up? Was there a back-up plan in place if that emergency room physician was tied down with an automobile accident or a trauma victim? Rushed decisions tend to be bad decisions.

The attorney needs to understand that the ER physician is only one part of the equation. What functions did hospital staff perform? Were nursing and respiratory care staff available for consultation? Were there sufficient staff to monitor the patient? Were the most current algorithms and policies and procedures of that hospital available? Was a pharmacist available to consult? Essentially the attorney must reconstruct what went on inside the ER during the time the patient was there, and analyze it. The attorney also must understand the medications involved, including medications the patient was on before coming into the hospital. For instance, with a head trauma, it would be nice to know whether the patient was already on heparin. Had the patient had a prior heart condition that required them to be on a blood thinner? That would perhaps raise the possibility of a hemorrhagic problem in the brain as opposed to simply a traumatic problem without the hemorrhaging.

These are all challenges to the lawyer who wants to take on the emergency case. The first step is to learn the medicine as well as the doctors, and to understand the standards of
care. There are many sources of guidance available to help determine whether one or more emergency physicians fell below the standard of care in providing treatment to your client.

James Bartimus has over 35 years trial experience representing plaintiffs nationwide in complex medical negligence cases. Upon completing law school, Mr. Bartimus attended medical school for three years. He is listed in the Best Lawyers of America and Super Lawyers for both Kansas and Missouri and was voted Best Medical Negligence Lawyer in Missouri.

Mr. Bartimus is a Fellow of IATL, American College of Legal Medicine, and currently serves on the Executive Committee as Vice President of the International Society of Barristers. He has been President of the Civil Justice Foundation, Missouri Association of Trial Attorneys, KC Metropolitan Bar Association, KC Metropolitan Bar Foundation, Missouri Institute for Justice, the regional chapter of the American Board of Trial Advocates, and UMKC Law Foundation.

Mr. Bartimus has taught as an adjunct professor at the University of Missouri at Kansas City School of Law and as adjunct faculty at the School of Nursing. He has lectured nationwide, in Europe, and in Australia. He is a contributing author to a number of textbooks and has written extensively for national legal publications. Mr. Bartimus is a founding partner of the law firm of Bartimus Frickleton Robertson & Gorny, (http://www.bflawfirm.com/Default.aspx ) with offices in Missouri and Kansas.
IV. STRATEGIES FOR AVOIDING LIABILITY FOR EMERGENCY CARE

A. Hospital-Employers and Risk Managers

What are potential strategies that the hospital-employer and risk manager may use in litigation involving emergency care?

Use Pre-Litigation Practical Tools
The following practical tools and approaches are now being implemented in a number of hospitals. Hospital administrators, insurers, and others should consider this type of implementation as a strategy to prevent malpractice and other lawsuits:

- Mandatory checklists for physicians and others evidencing compliance with guidelines and protocols
- Computer-assisted diagnostics
- Procedures for alerting patients and their doctors about urgent lab results after the patient’s discharge from the emergency room.


Determine Status of Health Care Provider
The hospital-employer and risk manager should determine the status of the emergency physician or other health provider to determine whether an employer-employee relationship exists. If this relationship does not exist and the health provider would be considered an independent contractor, the hospital may not be found liable under respondeat superior. However, under agency principles, if it can be proved that the emergency physician or other health provider had ostensible authority to act for the hospital, liability may be imposed. For a complete discussion of respondeat superior liability and agency principles see the full Medical Law Perspectives Report: *When Urgency Leads to Errors: Liability for Emergency Care* ([http://medicallawperspectives.com/IssueView.aspx?Issue=ww_20121205](http://medicallawperspectives.com/IssueView.aspx?Issue=ww_20121205))

Note: Defense counsel should consider the approaches discussed for the other defending parties to the litigation on these issues.

Important Hospital Vicarious Liability Cases

A court found that an allegation that a hospital had a non-delegable duty to supervise an independent contractor emergency room physician was enough to state a claim against
the hospital for vicarious liability. Under the hospital’s implied contract with the patient, the hospital had a non-delegable duty to provide competent emergency room treatment. The court also noted that a hospital can be held liable in tort for failing to exercise due care in the selection and retention of an independent contractor physician on its staff. See: Newbold-Ferguson v. AMISUB (North Ridge Hospital), Inc., 85 So.3d 502 (Fla.App. 4 Dist., Feb 22, 2012), rehearing denied (May 08, 2012).

A physician was not an actual agent of a hospital, and thus the hospital was not vicariously liable for his alleged medical malpractice despite the fact that the physician worked exclusively for the hospital; the hospital did not provide malpractice insurance or employee benefits to the physician, did not directly compensate him, did not bill his patients or their insurance for his services, did not withhold any taxes for state, federal, or local payroll or income tax purposes on his behalf, and could not terminate his employment without cause or notice. See: Foster v. Southern Regional Health System, Inc., 2012 WL 5519749 (Ga.App. Nov 15, 2012) (not designated for publication).

Courts have suggested that a hospital may be able to avoid vicarious liability under an apparent agency theory by posting a conspicuous sign in the admissions area that the emergency room physicians are not hospital employees, and having the patient sign an acknowledgment of this status. See: Cooper v. Binion, 598 S.E.2d 6 (Ga.App. Feb 18, 2004), reconsideration denied (Apr 01, 2004), cert. denied (Feb 21, 2005). Cooper, however, has been superseded by statute, as stated in Pendley v. Southern Regional Health System, Inc., 704 S.E.2d 198, 201 (Ga.App. Nov 24, 2010). The Pendley court noted that in 2005 the Georgia legislature enacted OCGA § 51–2–5.1(f) and (g), which effectively superseded Cooper by allowing the language of the contract to control. When a contract is absent, unclear, or ambiguous the statute provides new factors and eliminates many of the old eleven factors used in making the determination of whether the relationship is one of employer-employee or employer-independent contractor. See: Pendley v. Southern Regional Health System, Inc., 704 S.E.2d 198 (Ga.App. Nov 24, 2010).

For the hospital-employer to be found not subject to respondeat superior liability and for the risk manager to avoid liability for emergency care, proof must be presented that:

- There was no employee-employer relationship or agent-principal relationship; the emergency physician was an independent contractor, or was not affiliated with the hospital, or the hospital did not control the emergency physician

- Even if an employee-employer or agent-principal relationship existed between the hospital and the emergency physician, the physician’s acts or omissions were not within the scope of the employment, or the act or omission did not occur within the scope of the physician-employee or agent’s authority

- Alternatively, the elements required to establish the physician-employee or agent’s liability in a negligence suit do not exist
See the Hospital-Employer and Risk Manager Checklist providing an example fact checklist that can be used to determine vicarious liability.

**B. Insurers**

*What are potential strategies that the insurer may employ in litigation involving emergency care?*

**Examine Policy; Investigate Injury**

The insurer should examine the policy coverage and investigate the circumstances of the plaintiff’s injury. As part of this, it should be determined whether the injury was caused by the insured health provider’s actions, and if so, whether the insured health provider was negligent. For a complete discussion of the insurer’s investigation see the full Medical Law Perspectives Report: [When Urgency Leads to Errors: Liability for Emergency Care](http://medicallawperspectives.com/IssueView.aspx?Issue=ww_20121205)

For the insurer to be successful in medical malpractice litigation involving emergency medical treatment, and avoid or limit medical malpractice coverage, proof must be presented that:

- The insured health provider provided a high standard of care
- The insured health provider did not breach the applicable standard of care
- The insured health provider’s actions were not a proximate cause of the injury
- Alternatively, the injury was caused by the actions of another health provider or by defective equipment
- Alternatively, the insurance policy did not provide coverage for the alleged medical malpractice

See the Insurer Checklist providing an example fact checklist that can be used to determine liability for injuries resulting from emergency care.

**Important Insurance Coverage Case**

The insurer should carefully evaluate whether it has a duty to defend under the policy, noting that exclusionary insurance clauses generally are interpreted narrowly, while coverage clauses are interpreted broadly, in order to provide the greatest possible protection to the insured. The insurer should also review whether the malpractice insurance policy is an “occurrence” policy or a “claims-made” policy and look carefully at the date of the occurrence and the date the claim is made to determine its liability under the policy. In an occurrence policy, coverage attaches when the occurrence takes
In Wright, an adult patient with Down Syndrome brought a medical malpractice action alleging that an emergency room physician breached the applicable standard of care when the physician failed to verify the results of a urine test, which contributed to the patient’s eventual coma, insulin shock, and stroke. The alleged malpractice occurred on November 8, 1998. The patient’s initial complaint, filed on November 5, 1999 named only the medical center as the healthcare provider. On November 2, 2000 the complaint was amended to name the emergency room physician and a general surgeon. The emergency room physician was an employee of the hospital. The insurance company providing malpractice insurance to the emergency room physician denied coverage, arguing that its policy was a claims-made policy, covering claims made between November 1, 1999 and November 1, 2000. Although the policy would have covered the alleged malpractice occurring on November 8, 1998 if the claim had been made during the claims-made period, the patient did not name the emergency room physician in his complaint until the day after the claims-made period expired. The insurer argued that, as a result, there was no coverage. The patient argued that the claim made against the medical center, which was made against the medical center, which was made before the end of the claims-made period, should be effective against the physician. However, the court rejected this argument because the medical center was not insured under the same policy as the physician. The court also held that the 60-day extended reporting period under the physician’s policy, which gave the physician an extension of time to report potential claims to the insurer, did not give the patient an extended 60-day period in which to make a claim. See: Wright v. Willis-Knighton Medical Center, 57 So.3d 382 (La.App. 2 Cir., Jan 19, 2011), reh’g denied (Feb. 24, 2011), writ granted, 63 So.3d 972 (La. May 20, 2011).

C. Physicians and Health Providers

What is a potential strategy for the physician or health provider to employ when defending an action involving emergency care?

Prove High Standard of Care; Disprove Proximate Cause

Proof that the physician satisfied the standard of care owed to the patient may avoid liability for injuries involving emergency medical treatment. In the alternative, the defendant-physician may be able to show that any negligence that may have occurred was not the proximate cause of the plaintiff’s injuries. For a complete discussion of physician malpractice liability see the full Medical Law Perspectives Report: When Urgency Leads to Errors: Liability for Emergency Care (http://medicallawperspectives.com/IssueView.aspx?Issue=ww_20121205)
For a physician to be successful in litigation involving injuries related to emergency medical treatment, and avoid malpractice, proof must be presented that:

- The physician did not breach the standard of care owed
- The physician provided a high standard of care
- Even if the physician did make a mistake in providing emergency medical treatment, the physician’s actions were not a proximate cause of the patient’s injury

See the Physician’s Checklist providing an example fact checklist that can be used to determine liability for injuries resulting from emergency medical treatment.

**Important Cases on Expert Testimony and Malpractice**

Expert testimony usually will be required to establish the applicable standard of care and a breach of that standard. A physician who was board-certified in family medicine and geriatrics, certified as an instructor in advanced trauma life support and advanced pediatric life support, and who was a supervising physician/medical director at a rural health clinic was found not qualified to provide expert testimony in a case involving a patient treated in an emergency room after falling from a six-foot scaffold and suffering a spinal cord injury. The court agreed with the defendant-physician that nothing in the expert’s report or his curriculum vitae showed “the requisite knowledge of accepted standards of medical care for the diagnosis, care, or treatment of a suspected spinal cord injury due to a fall or the qualifications to express an opinion on causation” and that the expert’s qualifications showed no training or experience in providing emergency medical care in general or emergency care for a suspected spinal cord injury. The court also found that even if the expert’s credentials had qualified him to provide an expert opinion, the expert’s opinion did not adequately address the applicable standard of care, the breach of that standard, and the causal link between the alleged breach of the standard of care and the patient’s injuries. See: *Hagedorn v. Tisdale*, 73 S.W.3d 341 (Tex.App.-Amarillo, Jan 03, 2002).

One court noted that in a medical malpractice action against a physician, the plaintiff “carries a two-fold burden of proof.” First the plaintiff must establish by a preponderance of the evidence that the physician's treatment fell below the ordinary standard of care expected of physicians in the same medical specialty, and then the plaintiff must establish a causal relationship between the alleged negligent treatment and the injury sustained. In that case, the court found that the preponderance of the evidence indicated the physician “exhibited the skill and knowledge possessed by emergency room physicians in his treatment” of the patient, that the patient died of a sudden, unpredictable event, and that nothing the emergency physician did or did not do deprived the patient of a chance of survival. See: *Snia v. United Medical Center of New Orleans*, 637 So.2d 1290 (La.App. 4 Cir. May 26, 1994), writ denied, 644 So.2d 637 (La. Oct 07, 1994).
In some states, the standard of care required may be stated in a medical malpractice statute. In *Turner v. Franklin*, the court found no evidence that the emergency room radiologist breached the standard of care with wilful and wanton negligence when diagnosing and treating the patient based on an ultrasound, as required under the statute to support the medical malpractice claim of the patient's parents against the radiologist. The expert's report – which did not address whether the emergency room radiologist was subjectively aware of an extreme risk or acted with conscious indifference to the rights, safety, or welfare of others – failed to raise a genuine issue of fact about whether the radiologist's alleged error was anything more than mere negligence. See: *Turner v. Franklin*, 325 S.W.3d 771 (Tex.App.-Dallas Aug 13, 2010), reh’g overruled (Nov 09, 2010), review denied (2 pets.) (May 27, 2011).

Even if the physician can be shown to have deviated from the standard of care, it may be possible to avoid liability by showing that the physician’s breach was not the proximate cause of the patient’s injury. For example, in order to prevail on a medical malpractice claim that is based on a delay in providing medical treatment, the plaintiff must prove that the breach of the standard of care represented by the delay in treatment proximately and probably caused actual injury to the plaintiff. See: *Crutcher v. Williams*, 12 So.3d 631 (Ala. Mar 14, 2008).

**D. Plaintiff’s Attorney**

**What is a potential strategy for a plaintiff’s attorney to employ in medical litigation on emergency care?**

**Present All Elements of Cause of Action**
For an action in medical negligence or malpractice, the attorney will have to present evidence of the prima facie elements of the cause of action, including the legal duty owed by the defendant to the plaintiff, the breach of that duty that proximately caused the plaintiff’s injury, and the resulting damages. For a complete discussion of physician malpractice liability see the full Medical Law Perspectives Report: [When Urgency Leads to Errors: Liability for Emergency Care](http://medicallawperspectives.com/IssueView.aspx?Issue=ww_20121205)

For plaintiff’s counsel to be successful in litigation involving medical malpractice or negligence in providing emergency medical treatment, investigation of the facts and circumstances must be conducted and proof must be presented showing:

- The existence of a physician-patient relationship creating a duty of care owed by the physician to the patient
- The applicable standard of care the physician proving the emergency medical treatment owed to the patient
- The manner in which the physician breached that standard of care
The breach proximately caused the patient’s injury

The damages resulting from the breach

See the Attorney’s Checklist providing an example fact checklist that could be used demonstrate proof of medical malpractice for injuries involving emergency medical treatment.

**Important Cases on Relationship and Standard of Care**

A doctor does not enter into a physician-patient relationship with any patient who comes into the emergency room simply by being “on call” to treat emergency patients. The doctor must commit some “affirmative act that establishes the doctor-patient relationship.” Without an affirmative act, no relationship is formed and the doctor has no duty to the patient. See: **Ortiz v. Shah**, 905 S.W.2d 609 (Tex.App.-Hous., 14 Dist., Jun 08, 1995), reh’g overruled (Aug 31, 1995), writ denied (Nov 16, 1995).

A physician may agree in advance with a hospital to the creation of a physician-patient relationship that leaves the physician no discretion to decline treatment of the hospital's clients. However, a physician who is not under a contractual obligation with a hospital to provide services and who is not required to be “on call” to maintain staff privileges owes no general duty to emergency room patients. When no prior relationship exists between the physician and a patient, an on-call physician may assume a duty to the patient by taking some affirmative action to treat the patient, such as evaluating information provided by telephone and making a medical decision. See: **Lection v. Dyll**, 65 S.W.3d 696 (Tex.App.-Dallas, Jun 20, 2001), review denied (Nov 08, 2001). In contrast, where a specialist was not on-call, declined to receive detailed information from which to diagnose a patient, made no diagnosis, and ordered no treatment, but instead merely agreed to see the patient the next day, no physician-patient relationship was established. See: **Ortiz v. Glusman**, 334 S.W.3d 812 (Tex.App.-El Paso, Feb 16, 2011), reh’g overruled (Mar 30, 2011), review denied (Sep 09, 2011).

Determining the appropriate standard of care that applies to a physician providing emergency medical treatment may also be an issue. Physicians providing emergency medical care are increasingly being held to the standard of a specialist in emergency medicine. For example, one court found that a doctor who was practicing emergency medicine at the time of the alleged malpractice and who potentially could obtain board certification in emergency medicine was a specialist in emergency medicine. As a result, the patient's expert testimony needed to be provided by a specialist in emergency medicine. See: **Reeves v. Carson City Hosp.**, 736 N.W.2d 284 (Mich.App., Mar 08, 2007), appeal denied, 743 N.W.2d 894 (Mich., Feb 01, 2008).

In some states, the applicable standard of care has been modified by statute. For example, under a Texas statute (V.T.C.A., Civil Practice & Remedies Code § 74.153) a lower standard of care applies to emergency room health providers, which requires a patient to
prove that the health care provider acted with willful or wanton negligence. See: Dill v. Fowler, 255 S.W.3d 681 (Tex.App.-Eastland Apr 10, 2008) (medical malpractice statute that decreased standard of care for emergency room health care providers and required plaintiff to prove that health care provider acted with willful or wanton negligence did not violate equal protection, but was rationally related to state's concern over medical malpractice crisis and its materially adverse affect on delivery of health care and state's interest in ensuring availability of emergency health care).
V. CHECKLISTS

A. HOSPITAL-EMPLOYER AND RISK MANAGER CHECKLIST

In the case of a hospital that could be considered the employer of an emergency room physician, nurse, or other healthcare provider, the hospital should be concerned with possible respondeat superior liability for injury from errors in emergency treatment.

The following should be considered when determining if an emergency room physician, nurse, or other healthcare provider was in an employer-employee relationship with the hospital and if the provider’s negligence occurred “in the course and scope of the employment”:

- Whether the emergency room physician is an independent contractor who has been granted hospital privileges only
- Whether any actions or inactions by the hospital gave the patient the reasonable belief that an independent contractor emergency room physician was the hospital’s employee or agent
- Whether the emergency room physician has an employment contract with the hospital and would be considered in an employee-employer relationship
- Whether the hospital has a contract with an independent corporation to manage the emergency room and provide emergency department services
- Whether the emergency room physician is required to follow hospital rules and regulations
- Whether the hospital controls staffing of the emergency room, including setting requirements for the number of physicians to be in attendance and the levels or qualifications of the physicians required to be in attendance (for example, whether residents may be used)
- Whether the prescription pads emergency room physicians use to give prescriptions to emergency room patients show the hospital logo
- Whether a nurse or other non-physician healthcare provider was acting under the direction and control of the hospital or a hospital employee-physician or an independent contractor physician or independent emergency department at the time any negligent act was performed
- Whether the emergency room physician’s error resulting in injury to the patient was in the course and scope of the employment or would be considered outside the scope of the employment
• Whether the patient’s injury flowed directly from the emergency room physician’s or other provider’s error (expert testimony will be required)

Important References

*Hospital liability as to diagnosis and care of patients in emergency room*, 58 A.L.R.5th 613

*Liability for negligence of ambulance attendants, emergency medical technicians, and the like, rendering emergency medical care outside hospital*, 16 A.L.R.5th 605

*Proof of Negligence by Hospital Emergency Room Nurse*, 31 Am. Jur. Proof of Facts 3d 203


For the complete Medical Law Perspectives Report see: [When Urgency Leads to Errors: Liability for Emergency Care](http://medicallawperspectives.com/IssueView.aspx?Issue=ww_20121205)

**B. INSURER CHECKLIST**

When investigating a claim of malpractice in emergency medical treatment, the insurer should carefully evaluate the actions of the health provider and hospital. The insurer and defense counsel should look for the following “red flags” and consider how they impact the insurance coverage and liability for payouts.

The Health Provider’s Failure to:

• Provide immediate emergency care (such as CPR)

• Review the patient’s medical history (to the extent records were available and the time permitted under the emergency circumstances)

• Evaluate the patient completely (including ordering necessary tests such as a CT scan)

• Determine the diagnosis

• Provide the proper treatment

• Make full and complete notations in the patient’s medical records
The Hospital’s Failure to:

- Use sterile, sanitary, and other procedures (including proper hand washing)
- Maintain emergency medical equipment in good working order
- Follow protocols or mandated guidelines for emergency care
- Stabilize the patient’s emergency condition before transferring the patient

The Patient’s Failure to:

- Follow discharge instructions from emergency medical providers
- Take any prescribed medication properly
- Seek follow-up care, as directed by emergency physician or when condition lingered or worsened
- Avoid harm (Example: failed to follow sanitary procedures)

Review of the Professional Liability Coverages

- The insurer must carefully review and understand the coverages considering the duty to defend the physician-defendant or hospital, the exclusions, and non-covered conduct.

**Important References**

_Hospital liability as to diagnosis and care of patients in emergency room_, 58 A.L.R.5th 613

_Proof of Negligence by Hospital Emergency Room Nurse_, 31 Am. Jur. Proof of Facts 3d 203

_Malpractice by Emergency Department Physician_, 47 Am. Jur. Proof of Facts 2d 1

For the complete Medical Law Perspectives Report see: [When Urgency Leads to Errors: Liability for Emergency Care](http://medicallawperspectives.com/IssueView.aspx?Issue=ww_20121205)
C. PHYSICIAN AND HEALTH PROVIDER CHECKLIST

The other parties to the litigation will scrutinize the treating physician, medical experts, diagnosis, and treatment provided. The following should be evaluated, and strategies to defend against any perceived improper diagnosis or treatment should be considered and prepared.

Patient Sought Emergency Treatment from Defendant Physician

- Patient-plaintiff’s stated symptoms (such as pain) and observable medical problems (such as bleeding)
- Date emergency care provided by physician
- Dates of any subsequent care and other contacts with physician

Patient Medical History

- Evaluation of patient’s medical history (to extent records were available and time permitted under the emergency circumstances)

Proof of Physician’s Duty of Care

- Physician-patient relationship
- Physician exercised independent medical judgment on behalf of patient
- Expert testimony establishing the physician’s standard of care in emergency situations or when providing emergency care

Diagnosis and Treatment by Physician-Defendant

- Initial evaluation of patient by physician in emergency room or under emergency situation
- Appropriate emergency care provided (such as CPR)
- Appropriate medical screening examination performed under the circumstances
- Appropriate diagnostic testing ordered or performed
• Physician’s diagnosis demonstrated in the medical records

• Physician obtained appropriate consent (either informed consent or, alternatively, implied consent if applicable in the emergency situation)

• Physician provided the proper treatment as stated in the witness testimony

• Physician provided treatment on a timely basis

• Physician provided appropriate discharge instructions

Proof of No Breach of Standard of Care

• Facts showing high standard of care given to patient

• Expert testimony demonstrating no deviation from the applicable standard of care

• Protection available under Good Samaritan statutes, if applicable

Physician’s Treatment Did Not Cause Patient's Injury

• Expert testimony showing no proximate causation between physician’s care and the patient’s injury

• Expert testimony demonstrating other causes of patient’s injury (for example, the condition triggering the medical emergency)

• Evidence of negligent conduct by patient that contributed to injury (for example, refusing treatment or terminating treatment)

• Evidence of intervening causes that resulted in the patient’s injury (for example, negligent acts by another medical provider unknown to/unrelated to the physician)

Patient’s Damages

• Patient had no damages

• Damages claimed by patient from emergency treatment can be shown not to exist
Experts Supporting the Health Provider Can Be Qualified as Experts

- Experts can demonstrate their educational qualifications
- Experts can demonstrate their professional qualifications

**Important References**

*Malpractice by Emergency Department Physician, 47 Am. Jur. Proof of Facts 2d 1*

*Liability of Hospital or Other Emergency Room Service Provider For Injury To Patient or Visitor, 67 Am. Jur. Trials 271*

For the complete Medical Law Perspectives Report see: [When Urgency Leads to Errors: Liability for Emergency Care](http://medicallawperspectives.com/IssueView.aspx?Issue=ww_20121205)

**D. Plaintiff’s Attorney Checklist**

Counsel must develop a list of facts and circumstances, specific to the client’s fact situation, which demonstrates proof of liability in emergency medical circumstances. The following checklist is an example of a checklist that could be used to demonstrate proof of a physician’s malpractice involving emergency medical care.

**Patient Sought Treatment from Physician-Defendant**

- Patient-plaintiff’s symptoms (such as limb numbness) and observable medical problems (such as seizure)
- Date and time of first physician-patient emergency care contact
- Dates of any subsequent care and other contacts with physician

**Patient Medical History**

- Information in patient’s medical history contraindicated treatment provided (such as the incompatibility of a prescription patient concurrently using an IV medication)
- Responsible party accompanying patient provided information about patient that was disregarded by physician (such as a history of allergic reaction)
Proof of Physician’s Duty of Care

- Proof of physician-patient relationship
- Physician duty to exercise independent medical judgment on behalf of patient
- Expert testimony establishing the physician’s standard of care in emergency situations or when providing emergency care

Diagnosis and Treatment by Physician-Defendant

- Initial evaluation of patient by physician in emergency room or under emergency situation
- Emergency care needed (such as stopping bleeding) and provided (such as blood transfusion)
- Extent of medical screening examination performed under the circumstances
- Diagnostic testing ordered or performed (such as X-ray)
- Physician’s diagnosis
- Treatment provided by physician
- Timeline for evaluation and treatment by physician
- Physician’s referral of or failure to refer patient care to a specialist, such as a trauma surgeon, if applicable

Proof of Breach of Standard of Care

- Facts showing a breach of emergency treatment standard of care
- Expert testimony demonstrating a deviation from that standard of care
- Physician’s delay in providing treatment
- Physician’s failure to disclose risks of treatment
- Physician’s failure to discuss alternatives
- Physician’s failure to obtain informed consent
- Physician’s discharge of patient without instructions or with inadequate instructions

Physician’s Breach of Standard of Care Caused Patient's Injury

- Expert testimony showing proximate causation between physician negligent acts and the patient’s injury
- Expert testimony ruling out other causes of patient’s injury
- Absence of negligent conduct by patient that contributed to injury
- Absence of intervening causes that resulted in the patient’s injury

Patient's Damages

- Lost wages or business profits
- Present medical expenses
- Future medical expenses
- Other economic losses

**Important References**

*Malpractice by Emergency Department Physician, 47 Am. Jur. Proof of Facts 2d 1*

*Liability of Hospital or Other Emergency Room Service Provider For Injury To Patient or Visitor, 67 Am. Jur. Trials 271*

For the complete Medical Law Perspectives Report see: [When Urgency Leads to Errors: Liability for Emergency Care](http://medicallawperspectives.com/IssueView.aspx?Issue=ww_20121205)

Note: Counsel should consider the checklists provided for the other parties to the litigation.
VI. LITIGATION CONCERNS

A. Alternative Dispute Resolution

Arbitration

Arbitration or mediation may be required by contract or statute, mandated by the court or, in some circumstances, may be the appropriate method for a negotiated resolution.

A California court has held that a health care service plan offered by a health maintenance organization (HMO) involved interstate commerce. Because of this determination, the arbitration clause in the plan was covered by the Federal Arbitration Act (FAA). The court found that the plan covered Medicare subscribers and provided coverage for emergency patient care received anywhere in the world and for medication manufactured and distributed throughout the country. In this case, the insured under the health care services plan offered by the HMO, who had been denied coverage for certain recommended treatments, brought suit against the HMO and other entities that had allegedly provided benefit determinations and/or utilization review services. The HMO moved to compel binding arbitration with respect to the insured's claims against it. The Fourth District court granted Health Net's motion to compel arbitration, with the exception of the cause of action for public injunctive relief, which was severed from the arbitrable claims. Health Net was awarded its costs on appeal. See: Warren-Guthrie v. Health Net, 84 Cal.App.4th 804, 101 Cal.Rptr.2d 260 (Cal.App. 4 Dist. Nov 06, 2000), disagreed with on other grounds by Valencia v. Smyth, 185 Cal.App.4th 153, 171 (Cal.App. 2 Dist. Jun 01, 2010) (holding this arbitration agreement did not expressly adopt the FAA procedural provisions in this real property dispute). See also: Drissi v. Kaiser Foundation Hospitals, Inc., 543 F.Supp.2d 1076 (N.D.Cal. Jan 03, 2008) (a health plan's election form evidenced a transaction involving commerce because in some circumstances the plan paid for its members to receive medical services when traveling outside the state, and the plan provided coverage authorized by Medicare; holding the arbitration agreement in the health plan's election form bound the plaintiffs in this wrongful death action against the health provider alleging the mishandling of the patient's need for a kidney transplant).


For a comprehensive discussion of arbitration see <r>1 Alternative Dispute Resolution Practice Guide §§2:1 to 22:28</r>.

See also <r>Arbitration of medical malpractice claims, 24 A.L.R.5th 1</r>.
Mediation
An emergency appendectomy may affect mediation filings. In In re President Casinos, Inc., 397 B.R. 468 (8th Cir.BAP (Mo.) Dec 01, 2008), the court’s conclusion that the creditor's counsel failed to show that his illness established an excusable neglect warranting relief from an order that disallowed the creditor's postpetition personal injury claim against a Chapter 11 debtor, due to the creditor's failure to timely file a mediation statement, was not an abuse of the bankruptcy court's discretion. In this case, counsel's failure to provide details concerning the illness, such as the date on which his emergency appendectomy occurred and the length of time that he was incapacitated due to the illness, and counsel's concession that the missed mediation filing deadline stemmed, at least in part, from his failure to calendar it resulted in the lack of a finding excusable neglect.

For a comprehensive discussion of mediation see <r>1 Alternative Dispute Resolution Practice Guide §§23:1 to 35:7</r>.


B. Settlement of the Case
The hospital-employer and risk manager, insurer, physician and health provider, or plaintiff’s attorney may want to reach settlement and not take the action to trial. The following are illustrative reasons why settling the case may be the best outcome. Defense counsel should consider the reasons suggested for the other parties to the litigation.

Hospital-Employer and Risk Manager
The hospital is concerned that it may be have vicarious liability for the negligence of a physician. Although the physician who treated the patient was employed by an independent emergency physician staffing group under contract with the hospital, the hospital has not made it clear to patients that the emergency physician staffing group is independent. Consent forms, discharge instructions, and prescription pads used by the emergency physician staffing group all bear the hospital’s logo. The hospital also controls staffing levels in its emergency department, including the physicians provided by the emergency physician staffing group, which was understaffed when the patient arrived, resulting in a long delay in the patient receiving treatment. The hospital wants to prevent negative perception in the media.

Insurer
There are significant facts sympathetic to the patient. For example, the patient, who was involuntarily committed for psychiatric evaluation, was left unattended for more than 12 hours in an examination room near an unlocked exit. The patient left the emergency room and the hospital without being noticed by any staff members and wandered the
neighborhood, eventually running out onto a nearby highway, where she was hit by a car. The patient’s extensive injuries resulted in severe pain and permanent physical disability.

**Physician and Health Provider**

There is concern about an initial, inaccurate diagnosis and the treatment provided, resulting in a question of whether the physician met the standard of care. For example, the emergency room physician examined a woman complaining of chest pains and sent her home, without performing appropriate tests, admitting her to the hospital, or telling her how serious her condition was. The physician based his actions on his observation that the patient was not in severe distress at the time he saw her and his determination that her chest pains were not inconsistent with the patient having done some sweeping the previous day. The patient returned to the emergency room after several hours suffering from a heart attack and later died of a massive myocardial infarction.

**Plaintiff’s Attorney**

There are proof problems regarding proving the emergency room physician’s actions were a proximate cause of the patient’s injuries. For example, the defendant’s expert is expected to testify that even if the patient’s subdural hematoma had been diagnosed and treated earlier, it is unlikely that the patient’s death two weeks after surgery would have been avoided.

For the complete Medical Law Perspectives Report see: [When Urgency Leads to Errors: Liability for Emergency Care](http://medicallawperspectives.com/IssueView.aspx?Issue=ww_20121205)

**C. Taking the Case to Trial**

The hospital-employer and risk manager, insurer, physician and health provider, or plaintiff’s attorney may have a strong case and want to take the action to trial. The following are illustrative reasons why taking the case to trial may result in the best strategy and result in a good outcome. Defense counsel should consider the reasons suggested for the other parties to the litigation.

**Hospital-Employer and Risk Manager**

It is unlikely the emergency physician will be found to be an employee or agent of the hospital, and claims by several other patients involving the medical care provided by this physician during the same week will be favorably impacted by a finding that the hospital is not liable for the negligence of this physician.

**Insurer**

The insurer for the hospital has been unable to reach settlement with the patient. The patient is likely to have problems proving that any acts or failures by the hospital or any of its employees proximately caused the patient’s injuries. Success at trial would avoid payout on the hospital’s policy if negligence is not found.
Physician and Health Provider
A review of the medical records by a consulting expert strongly indicates no evidence of negligence or malpractice by the health provider, and the emergency physician met or exceeded the standard of care. Also, the patient’s own actions indicate patient fault, such as the patient’s failure to follow the emergency room physician’s discharge instructions, including the failure to take prescribed medication and the failure to keep follow-up appointments with medical specialists. Physician liability likely will not be found.

Plaintiff’s Attorney
Expert testimony by a noted authority in the field will state that the emergency physician’s negligence in failing to administer greater amounts of intravenous fluids to a child who arrived at the emergency room with signs of dehydration and impending shock was a proximate cause of the child’s death. Autopsy results indicated that the cause of death was electrolyte imbalance due to dehydration and the death of their only child is likely to elicit sympathy for the child’s parents. Physician liability likely will be found.

For the complete Medical Law Perspectives Report see: When Urgency Leads to Errors: Liability for Emergency Care

D. Jury Verdicts and Settlements
Litigation involving emergency care has resulted in significant jury awards and settlements. Hospital-employers and risk managers, insurers and defense counsel, physicians and health providers, and plaintiff’s attorneys must be aware of the potential damages in these actions.

Award Total: $144,690,039
October 1, 2012
Medical malpractice of hospital and physician for failure to timely diagnose and treat patient’s heart attack

The patient presented to the emergency room at the first hospital, a subsidiary of a healthcare network, with chest pain radiating into her left arm, neck, and jaw the morning of Jan. 26, 2009. She was given an EKG that revealed an acute ischemic injury pattern with ST segment depressions and hyper acute T-waves in anterior-anterolateral distribution. The hospital reportedly administered medications and three hours later, gave the patient another EKG. An emergency room physician allegedly read the second EKG as normal and took no immediate action with regard to the patient's condition. Later, a cardiologist reportedly read the second EKG results and noted the results were abnormal, with ST segment elevations in anterior and mid-precordial leads consistent with an ischemic event.

The patient was admitted to the floor of the hospital and allegedly left mainly unattended, except for the administration of anti-nausea medication and narcotic pain medication.
Around 10:00 p.m., her blood work reportedly was returned and allegedly indicated elevated troponin levels, apparently confirming that she had experienced a myocardial infarction, or heart attack. At that time, the patient reportedly was placed on Lovanox and a cardiac consultation was requested.

The next morning, a family member visited the patient in the hospital and called his own cardiologist for a second opinion. This new cardiologist immediately went to the hospital, examined the patient, reviewed the EKG, and ordered that the patient be transferred to the Intensive Coronary Care Unit, where the new cardiologist proceeded to administer heparin and make arrangements for the patient to be emergently transferred to a second hospital for a cardiac catheterization.

Upon arrival at the second hospital, the second hospital’s cardiologist diagnosed the patient with an ongoing heart attack and ordered that she be transported into the cardiac catheterization lab where a cardiac catheterization was performed. According to the patient's attorney, a 99 percent stenosis of the left anterior descending artery was found and a stent was placed which opened the artery. Simultaneously, it was determined that there had been a dissection of the coronary artery at or near its intersection with the left anterior descending artery and the circumflex artery, stopping blood flow. Later, an open heart procedure and a double bypass were performed to bypass the dissection and the stented occlusion.

The patient filed a lawsuit against the first hospital, the healthcare network, and three physicians (the emergency physician who first examined the patient; the doctor who examined the patient after she was admitted to the hospital and assigned a room; and the cardiologist who observed the patient at the first hospital the night of Jan. 26, 2009, and the following morning).

The patient-plaintiff, in her complaint, alleged the defendants were negligent in their care and/or treatment by failing to adequately and/or timely evaluate, assess, diagnose and/or treat her, thereby causing her to sustain damage to her heart and/or exacerbate her preexisting cardiac condition.

The patient-plaintiff sought damages for her medical expenses, past and future lost wages, mental anguish, loss of enjoyment of life, and fear of death.

According to the patient-plaintiff’s attorney the patient sustained significant damage and death to her myocardium, resulting in the formation of scar tissue in the front and bottom of her heart. The patient-plaintiff’s attorney maintained that as a result, the patient's heart was deficient and could not provide adequate blood flow, causing a marked decrease in stamina. The patient-plaintiff’s attorney stated the patient required a defibrillator and could no longer work at her job as a construction bookkeeper. The patient-plaintiff’s attorney added that the patient would probably be placed on left ventricular assist device, or LVAD.
The first hospital defendant denied the allegations and claimed the patient-plaintiff had a small, insignificant myocardial infarction in the emergency room of the hospital and received proper treatment in the moments and hours directly following the cardiac event. The first hospital defendant allegedly argued the damage to the patient's heart and scar tissue were present at the time of her arrival to the emergency room and not caused by hospital physicians or staff.

The case proceeded to a jury trial against the first hospital only. The jury returned a verdict in favor of the patient-plaintiff on Oct. 1, 2012, awarding damages of $144,690,039.

See: Shol v. A.O. Memorial Hospital, 2012 WL 5264842 (N.Y.Sup.) (not designated for publication).

**Award Total: $5,000,000**

**September 1, 2012**

**Hospital medical malpractice regarding psychiatric patient resulting in catastrophic brain damage, multiple fractures, and death**

The 24-year-old patient arrived at the defendant medical center's emergency room in April 2011, with suicidal and homicidal ideation and signs of severe depression. The patient was involuntarily committed for psychiatric evaluation. Following the patient’s admission to the medical center, the staff put him in a corner exam room near the back of the emergency department, which was adjacent to an unlocked exit. There were no nurses or security guards assigned to supervise the patient.

After nearly 18 hours in the exam room, the patient exited the hospital undetected. He was dressed in a blue hospital gown and red socks. About 10 hours later, he ran onto a highway about 1.5 miles from the medical center, and was struck by a motor vehicle. He died the next day from his injuries. No charges were filed against the driver.

The plaintiff, who was administrator of the patient decedent’s estate, alleged the medical center was negligent in failing to adequately assess and score the degree of the patient’s depression; failing to properly monitor and supervise the patient; and failing to prevent the patient from leaving the hospital after having been involuntarily committed for psychiatric evaluation. The plaintiff also argued that a similar accident had happened just three weeks before the patient's death and that no additional measures had been taken to ensure the patient's safety or to prevent other psychiatric patients from leaving the premises.

The defendant contended that its staff acted in accordance with hospital policy and contacted authorities as soon as the patient's absence was noticed. The defendant denied any negligence.

The jury found for the plaintiff and awarded a $5,000,000 verdict.

Award Total: $0
August 2, 2012
Emergency room physician failed to recognize patient's abnormal vital signs and order the proper tests and medication, resulting in the patient’s death three days later

The patient went to the emergency room at defendant hospital July 14, 2007 and received treatment from the defendant emergency physician, an agent of the hospital’s parent corporation, and of a physicians group; and a nurse, an agent of the hospital. According to the patient's parents, the patient's vital signs and pulse oximetry were abnormal but the emergency physician did not intubate her or order an arterial blood gas, Lasix, hand-held nebulizers or morphine.

The nurse provided oxygen therapy to the patient without consulting with the emergency physician. A radiologist, an agent of the hospital’s parent corporation and a radiology imaging group, reportedly failed to read a chest X-ray that was suggestive of congestive heart failure. The patient died July 17, 2007.

The plaintiff, as independent administrator of the patient's estate, as well as the patient’s parents, filed a lawsuit against the hospital and its parent corporation, the emergency physician, defendant hospital, the nurse, the radiologist, and the radiology imaging group. In their third amended complaint, the plaintiffs alleged the emergency physician was negligent in failing to recognize the patient's abnormal vital signs and pulse oximetry, failing to intubate her, and failing to order an arterial blood gas or Lasix.

The plaintiffs alleged the nurse was negligent in failing to timely observe and report the patient's abnormal vital signs and pulse oximetry, providing oxygen therapy without consulting the emergency physician, and failing to timely provide prescribed medication. They alleged the radiologist was negligent in failing to properly read the chest X-ray.

The plaintiffs sought damages under the Illinois Survival Act for the patient's pain and suffering, sought damages under the Family Expense Act for her funeral and burial expenses, and sought damages under the Wrongful Death Act for the loss of support and society sustained by her next of kin.

The case proceeded to trial with only the parent corporation, the emergency physician, and the hospital listed as defendants. The jury found in favor of the defendants Aug. 2, 2012.

Failure to diagnose and treat a cardiac condition, resulting in patient’s death

The patient, a 34 year old male, went to the defendant medical center's emergency room with complaints of severe back and abdominal pain, a headache, nausea, and numbness in his hand and foot. He also had a history of kidney stones. The patient was examined by defendant doctor who noted the patient's vital signs were within normal limits. The doctor provided medication for the pain and nausea, and then ordered a urinalysis and CT scan. At the end of his shift, the doctor handed off the case to a second physician who examined the patient and found no abnormalities with his vital signs. The CT came back unremarkable and the urine had trace amounts of bloods. The second physician believed the patient was passing another kidney stone and released him with instructions to return if his condition deteriorated.

Twelve hours after being released from the hospital, the patient's roommate found him unresponsive and called 911. An autopsy revealed a ruptured aortic dissection, which resulted in a fatal pericardial tamponade.

The plaintiff, administrator of the patient’s estate, alleged that the doctor and the second physician were negligent in failing to diagnose and treat the aortic dissection, resulting in the patient's death. Several physicians who testified concurred that defendants' failure to order additional tests or to seek alternative diagnoses was a violation of the standard of care.

The defendants contended that the care provided was reasonable and consistent with the patient's medical history. Defendants also inferred that the patient participated in risky behaviors which contributed to his cardiac condition and death.

A verdict for the defendants was rendered.

laceration of the patient's trachea. The physician was attempting to perform an emergency endotracheal intubation in an effort to address the patient's occurring respiratory failure.

The plaintiff estate contended the emergency service, under the theory of respondeat superior, and the physician were liable for the patient's death. The plaintiff alleged the physician failed to properly place the endotracheal tube which caused a severe tear or laceration in the patient's trachea, allowed air to leak into the patient's chest cavity resulting in extensive subcutaneous emphysema, and which caused the patient’s death.

The defendants denied negligence or liability, contending the physician met the reasonable standard of care when performing the endotracheal intubation and asserting affirmative defenses of independent intervening acts, the failure to mitigate damages, assumption of risk, open and obvious, and pre-existing conditions.

The decedent survived four days after the procedure and was survived by her life partner and their two adult children.

A verdict for the defendants was rendered.

See: Rode, as Special Administrator; Wendt, Estate of v. Dennis, MD; Fremont Emergency Service, 2012 WL 4762481 (Nev.Dist.Ct.) (not designated for publication).

**Award Total:** $1,810,000 which was subject to reduction to present value and 20% comparative negligence. The parties reached a confidential settlement prior to entry of the judgment.

**July 13, 2012**

Failure to timely diagnose and treat coronary artery disease, resulting in fatal cardiac arrest

This medical malpractice suit was filed by the plaintiff, the personal representative of the decedent’s estate, following the death of the 45 year old man from coronary artery disease. He had been evaluated at an emergency room a month earlier. The parties disputed whether the evaluation, which resulted in a relatively benign diagnosis, was proper.

The patient went to the defendant hospital's emergency room in December 2007. He had complaints of nausea and severe chest pain radiating into his arm and back. He was seen by defendant physician. An EKG was normal and his enzyme levels were not elevated. Also, a GI cocktail given to the patient reduced his pain. He was discharged after a few hours, with a diagnosis of peptic ulcer disease.

The following week, the patient went to his primary care physician (also a defendant) who concurred with the emergency room doctor's findings. As a result, no additional testing was ordered. A month later, the patient died as a result of total stenosis of the left anterior descending coronary artery, according to the autopsy.
The plaintiff alleged that the patient should have been admitted for further diagnostic testing, including a stress test, which would have shown the coronary artery disease. Plaintiff argued that the proper diagnosis would have led to successful lifesaving treatment. Plaintiff claimed that the patient had all the risk factors for heart disease, including obesity, high cholesterol levels, and a significant family history of heart disease. Plaintiff argued that a normal EKG and enzyme levels are not reliable diagnostic factors, unless the patient is having a cardiac infarction at the time. Moreover, plaintiff asserted that cardiac pain is often reduced with the administration of a GI cocktail.

The defendants contended that it was acceptable to discharge the plaintiff, given a normal EKG, normal enzyme levels, and pain reduction with a GI cocktail. Defendants maintained that the patient was provided with standard of care treatment and that his death was not related to this event.

The case was presented to a jury who awarded a $1,810,000 verdict to the plaintiff. The award was subject to reductions for comparative negligence and present value. The parties reached a confidential settlement prior to entry of the judgment. This was in addition to a confidential settlement with the decedent’s primary care physician a month before the trial.

See: Lizbeth Logan, Personal Representative of the Estate of Melvin Logan v. Providence Hospital, Sharon Bajwa, M.D., et al., 2012 WL 5489476 (Mich.Cir.Ct.) (not designated for publication).

VII. CASE LAW

The following is a listing of important cases regarding emergency care liability. See above in this report for case opinions and/or holdings.


Clelland v. Haas, 774 So.2d 1243 (La.App. 1 Cir. Dec 22, 2000)


Crutcher v. Williams, 12 So.3d 631 (Ala. Mar 14, 2008)

Daley v. Advocate Health & Hosps. Corp., 2012 WL 3862155 (Ill.Cir.Ct.) (not designated for publication)


Estate of Michael James Hunt, Jr. v. Wilson Medical Center, 2012 WL 5506957 (N.C.Super.) (not designated for publication)


Guadagno v. Lifemark Hospitals of Florida, Inc., 972 So.2d 214 (Fla.App. 3 Dist., Dec 05, 2007)
Hagedorn v. Tisdale, 73 S.W.3d 341 (Tex.App.-Amarillo, Jan 03, 2002)


Lection v. Dyll, 65 S.W.3d 696 (Tex.App.-Dallas, Jun 20, 2001), review denied (Nov 08, 2001)

Lizabeth Logan, Personal Representative of the Estate of Melvin Logan v. Providence Hospital, Sharon Bajwa, M.D., et al., 2012 WL 5489476 (Mich.Cir.Ct.) (not designated for publication)

Newbold-Ferguson v. AMISUB (North Ridge Hospital), Inc., 85 So.3d 502 (Fla.App. 4 Dist., Feb 22, 2012), rehearing denied (May 08, 2012)


In re President Casinos, Inc., 397 B.R. 468 (8th Cir.BAP (Mo.) Dec 01, 2008)


Robinson v. Adirondack Medical Center, 244 F.Supp.2d 66 (N.D.N.Y., Feb 07, 2003)

Rode, as Special Administrator; Wendt, Estate of v. Dennis, MD; Fremont Emergency Service, 2012 WL 4762481 (Nev.Dist.Ct.) (not designated for publication)


Salvatore v. Winthrop University Medical Center, 36 A.D.3d 887, 829 N.Y.S.2d 183 (N.Y.A.D. 2 Dept., Jan 30, 2007)

Shol v. A.O. Memorial Hospital, 2012 WL 5264842 (N.Y.Sup.) (not designated for publication)


Turner v. Franklin, 325 S.W.3d 771 (Tex.App.-Dallas Aug 13, 2010), reh’g overruled (Nov 09, 2010), review denied (2 pets.) (May 27, 2011)


Wilkins v. Marshalltown Medical and Surgical Center, 758 N.W.2d 232 (Iowa, Dec 5, 2008)

Wright v. Willis-Knighton Medical Center, 57 So.3d 382 (La.App. 2 Cir., Jan 19, 2011), reh’g denied (Feb. 24, 2011), writ granted, 63 So.3d 972 (La. May 20, 2011)

For the complete Medical Law Perspectives Report see: When Urgency Leads to Errors: Liability for Emergency Care
VIII. REFERENCE FOR FURTHER GUIDANCE

The following law and medical resources provide additional resources for information on emergency care liability.

*When Is Hearsay Statement Made to 911 Operator Admissible as "Excited Utterance" Under Uniform Rules of Evidence 803(2) or Similar State Rule, 7 A.L.R.6th 233*

*When Is Hearsay Statement Made to 911 Operator Admissible as "Present Sense Impression" Under Uniform Rules of Evidence 803(1) or Similar State Rule, 125 A.L.R.5th 357*

*Hospital liability as to diagnosis and care of patients in emergency room, 58 A.L.R.5th 613*

*Liability for negligence of ambulance attendants, emergency medical technicians, and the like, rendering emergency medical care outside hospital, 16 A.L.R.5th 605*

*Admissibility of tape recording or transcript of "911" emergency telephone call, 3 A.L.R.5th 784*

*Construction and application of "Good Samaritan" statutes, 68 A.L.R.4th 294*

*Liability for injury or death allegedly caused by activities of hospital "rescue team,” 64 A.L.R.4th 1200*

*Liability for failure of police response to emergency call, 39 A.L.R.4th 691*

*Duty of one other than carrier or employer to render assistance to one for whose initial injury he is not liable, 33 A.L.R.3d 301*

*Liability of Hospital or Other Emergency Room Service Provider For Injury To Patient or Visitor, 67 Am. Jur. Trials 271 (1998)*

*Establishing Hospital Liability under the Emergency Medical Treatment and Active Labor Act for "Patient Dumping,” 62 Am. Jur. Trials 119*


*Proof of Liability for Failure of Emergency Medical Equipment, 80 Am. Jur. Proof of Facts 3d 1*

*Proof of Negligence by Hospital Emergency Room Nurse, 31 Am. Jur. Proof of Facts 3d 203*

Inadequate Response to Emergency Telephone Call, 2 Am. Jur Proof of Facts 3d 583

Malpractice by Emergency Department Physician, 47 Am. Jur. Proof of Facts 2d 1

Lindsey J. Hopper, Striking a Balance: An Open Courts Analysis of the Uniform Emergency Volunteer Health Practitioners Act, 92 Minn. L. Rev. 1924 (June, 2008)


Medical Negligence: Making the Trauma Negligence Case, 44 Trial 22 (2008 WL 2137768)


Transportation: When Rescue is Too Risky, 42 Trial 28 (2006 WL 477961)

1 Attorneys Medical Deskbook § 2:17, Emergency records

1 Attorneys Medical Deskbook § 7:26, Encyclopedia of physician, paramedical, and allied health fields

1 Attorneys Medical Deskbook § 8:8, Emergency department

4 Attorneys’ Medical Advisor, Chapter 33 General Issues in Trauma

4 Attorneys Medical Advisor §§ 33:8, 33:9, 33:10, Regional Trauma Center

4 Attorneys Medical Advisor §§ 33:24 to 33:31, Emergency Care of Trauma Patients


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