

American College of Emergency Physicians RISK MANAGEMENT OUTLINE AND RESOURCES

This document was developed by the ACEP's Academic Affairs Committee as a resource document for residency programs and other groups to utilize in risk management education. This document is not intended to be a comprehensive review of risk management, but rather a resource document for educators. Users are encouraged to use original references listed throughout the document, and to update educational material as new references become available.

This document was developed in response to a 2004 Council Resolution:

Resolved, that the American College of Emergency Physicians (ACEP) Board of Directors appoint a task force to develop a standardized risk management curriculum and the needed supporting educational products to be used by residency programs in teaching risk management and tort law to residents and junior faculty.

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Appendix A (ACEP Resource Document): "So You've Been Sued"

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I. Top Ten Areas of Vulnerability in Emergency Medicine Practice

As with any specialty, the practice of emergency medicine has its own unique processes which are followed during the course of patient care. Each of these processes can be thwarted by barriers that increase risk and threaten patient safety. From the physician standpoint these barriers are known as “vulnerabilities”—potential medical-legal land mines that may be encountered in the practice of emergency medicine.

Below is a list of the ten most common vulnerabilities found in claims of medical negligence involving the emergency department (ED). Every emergency physician should be familiar with the items in this list. Emergency physicians should actively participate in an educational program specific to emergency medicine that is designed to improve patient safety while reducing risk for patients and physicians alike.

The importance of documentation is summed up in this quote: “Use the history, risk factors, exam, test results and ED course to shape your differential diagnosis and medical reasoning into a compelling story so logical that any reasonable physician and every juror can only come to one conclusion—yours.”

A. *Knowledge deficit*

Despite extensive education, training, and experience, the emergency physician will not have seen every variation of every condition that presents to the ED. For example, it may not be universally known that thoracic aortic dissection may present with stroke symptoms or abdominal pain with hematuria. While it is not possible to conquer the entire body of available medical knowledge, from a standpoint of risk and patient safety it is important for emergency physicians to focus on learning as much as possible about the ED presentations that are high risk – both for the patient and the physician.

B. *Failure to take adequate history*

The allegation of this failure is frequently found in medical negligence suits, and typically involves the absence of documentation of one or more key elements of the history of present illness, risk factors, past medical history, family history, or personal/social history. The basic skill of history-taking learned in medical school requires ongoing diligence and refinement in order to produce chart documentation which reflects that an adequate history has been obtained. One of the main areas of deficiency seen in suits is the lack of documentation of risk factors for serious conditions such as acute coronary syndrome, pulmonary embolism, aortic dissection, abdominal aortic aneurysm, and subarachnoid hemorrhage.

C. *Failure to perform adequate exam*

This failure may not be one of the most common allegations in malpractice suits, but when the allegation is made (and is true) the results can be disastrous. Every patient expects that an adequate physical examination will be performed and documented. If important elements of the physical exam are not documented, it will be assumed that the physician was sloppy and simply did not perform the exam. Some examples of alleged negligence include: failure to perform a neurological exam in a headache patient; failure to examine the mental status, neck, and skin in a febrile infant; and failure to document the presence or absence of a pulsatile abdominal mass and peripheral pulses in a patient over 50 who presents with abdominal or flank pain.

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- D. *Failure to consider differential diagnoses*
Optimally chart documentation should reflect the physician's medical reasoning, of which the differential diagnosis is a key component. Particularly for high risk chief complaints such as chest pain, abdominal pain, headache, and pediatric fever, it may be wise to document the principal differential diagnoses, accompanied by a brief discussion as to why those diagnoses were considered, dismissed or ruled out. If chart documentation does not include a discussion of medical reasoning and there is a bad outcome, the patient may resort to a lawsuit simply to find out what the physician was thinking.
- E. *Failure to order/interpret diagnostic studies*
For the lay public and medical profession alike, there are expectations that certain diagnostic studies will be needed based on the presenting symptoms and signs. This "failure" is a common allegation when a patient experiences an adverse outcome, and feels that lab tests, x-rays, electrocardiogram (EKG), or other tests should have been done but were not. Examples include failure to perform an EKG to evaluate chest pain, failure to perform a lumbar puncture (LP) for the patient with sudden severe headache and negative head computed tomography (CT), or failure to perform a pregnancy test for women of childbearing age with pelvic pain. Physicians are held responsible for interpreting the diagnostic studies they order. It is difficult to defend a physician who ignores abnormal test results that he/she ordered.
- F. *Failure to diagnose*
In emergency medicine, failure to diagnose is probably the most common claim of negligence, usually accompanied by at least one of the other "failure" allegations. The emergency physician is expected to combine his knowledge with the patient's history, exam, and diagnostic testing to arrive at the correct diagnosis. Although it is not always possible to diagnose conditions definitively in the ED, every effort must be made to use the resources available to arrive at and to record a reasonable provisional diagnosis before devising a disposition.
- G. *Failure to treat*
This vulnerability goes hand in hand with failure to diagnose. It follows logically that if there was a failure to diagnose, then there will likely be a concomitant failure to treat the missed diagnosis. Failures to treat allegations are also made when time sensitive treatment is delayed. Examples of allegations in this category include: failure to use heparin, aspirin, and beta blockers for acute coronary syndrome; failure to treat stroke with thrombolytics; and failure to administer antibiotics for pneumonia, meningitis, or sepsis in a timely fashion.
- H. *Failure to consult*
This allegation is self-explanatory. When a physician would be reasonably expected to consult a specialist and does not, and there is a bad patient outcome, the outcome can be used as proof of the need for consultation. Examples include early consultation for trauma patients; cardiology for acute myocardial infarction; orthopedics for open fractures; or vascular surgery for an ischemic limb.
- I. *Failure to admit*
The majority of malpractice claims in emergency medicine involve a patient who was discharged home from the ED and ended up suffering a complication. This failure is usually coupled with the allegation of failure to diagnose. Of all the decisions made

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during the care of a patient in the ED, the single most important decision is the disposition – whether to admit or discharge. The emergency physician should use a written or mental “template” to consider this list of vulnerabilities prior to discharging a patient who came to the ED with a high risk chief complaint. When the decision is made to not admit, the discharge instructions should always include these specific things: who to follow up with, when to follow up, expected course, and specific reasons to return to the ED.

J. *Failure to communicate*

Although this specific failure is rarely mentioned in a lawsuit, it serves as the foundation upon which almost all negligence claims and other allegations are built. It should be a part of every physician’s routine to explain the “who, what, when, where, and why” of the workup to the patient. Strategies include listening to patients and their families, soliciting and listening to ED staff input, and describing services as they are delivered to achieve patient and family understanding and satisfaction. Striving to achieve optimal patient satisfaction by treating patients as if they were your own relative, and communicating clearly and often what you are doing and why, is the best personal malpractice insurance you can procure. And it costs only time, and a modicum of empathy.

II. Charting and Documentation

A. *Goals and Objectives*

1. Describe the purpose of the medical record
2. Identify the key components of the physician’s medical record
3. Make appropriate alterations in the medical record
4. Appropriately document discrepancies between physician’s and nurse’s charting
5. List basic components of discharge/follow-up instructions
6. Describe different charting methods
7. Develop a plan to avoid risks with their specific charting method
8. Differentiate between effective and ineffective documentation with regards to risk management
9. Analyze five of their charts and describe documentation deficiencies from a risk management standpoint

B. *Content*

1. Purpose of Record
 - a. Communicate to other healthcare providers the care given. They should be able to tell exactly how patient presented, what care was given, how they responded, what the differential and provision diagnosis were, what the disposition was.
 - b. Justification of billing
 - c. Centers for Medicare and Medicaid Services’ (CMS) documentation guidelines
 - d. Documentation of care that protects the patient, hospital and health care providers. The medical record can be submitted as evidence.
2. Physician Record
 - a. History
 - Chief complaint
 - History of present illnesses (HPI)
 - Review of systems (ROS)
 - Personal, family, and social history (PFSH)
 - b. Exam

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- General multi-system examinations
- Single organ system examinations
- c. Complexity of medical decision making
- d. Number of diagnostic and management options
- e. Risk
- 3. Alteration of Physician Record
 - a. At time of care
 - Single line, error, initial, date and time
 - b. After care but prior to adverse outcome or notification of legal action
 - c. Addendum
 - d. After knowledge of legal action or outcome
 - May record recollection of case with legal counsel, not in patient chart
- 4. Nursing Record
 - a. Check for congruency and document if there is a discrepancy
 - b. Vital signs; repeat abnormal vital signs
 - c. Nursing education regarding appropriate documentation
- 5. Disposition and Follow-up
 - a. Working diagnosis
 - b. Follow-up
 - c. Why they would need to return
 - d. Simple language
- 6. Consultations
 - a. Risk of unofficial consult
 - b. Read and check for inconsistencies with your documentation
 - c. Realize their note may be slightly different from your conversation
- 7. Incident Report
 - a. Purpose
 - b. Components
 - c. Preventing discovery
- 8. Types of Medical Records: Advantages and Disadvantages
 - a. Handwritten
 - b. Scribe
 - c. Template
 - d. Transcription
 - e. Computer-generated voice recognition programs
- 9. High risk documentation
- 10. Miscellaneous
 - a. Legibility
 - b. Don't place incident report, quality improvement (QI) material in chart
 - c. Lost record

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III. Practice Management

Goals and Objectives

At the completion of training, the physician will be able to:

- A. Make sound ethical decisions appropriate for a board certified emergency physician
- B. Given a one hour lecture on medical ethics, the resident will be able to define the following terms with 100% accuracy: autonomy, nonmaleficence, beneficence, futility, and informed consent
- C. Given a one hour lecture on medical ethics, the resident will be able to discuss five steps in ethical decision making: assess the issues, identify the dilemma, consider alternative courses of action, implement the action, evaluate the action
- D. Given examples of medical cases with ethical issues, the resident will be able to use the five steps in ethical decision making to arrive at an ethical decision for each case.
- E. Maximize medical and legal risk reduction in the management of patients with high-risk chief complaints (i.e. chest pain, abdominal pain, pediatric fever, headache, etc.)
- F. Through in an in-depth interactive presentation on medical and legal issues in patients with high-risk medical complaints, the resident will be able to discuss the following:
 1. Common pitfalls of these clinical conditions and how best to document care in a defensible manner (advice given to the patient, the thought processes behind diagnostic workup and management plan)
 2. Life-threatening diagnosis that should be considered in the differential diagnosis of these patients
 3. Appropriate diagnostic strategies and management of these patients
- G. Given recent cases at a monthly emergency medicine (EM) Morbidity and Mortality conference, the resident will be able to:
 1. Identify deficient areas in the workup of the ED patient in each case
 2. Discuss how the patient (s) could be managed differently to minimize any medicolegal risk for each case
 3. Discuss how to document care in a defensible manner

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4. Discuss the importance of a multidisciplinary approach to quality assurance (involve nursing staff, radiology, lab)
5. Perform operational risk reduction in the ED in the following areas:
 - a. Facility
 - b. Privacy
 - c. Equipment
 - d. Security
 - e. Safety
 - f. Credentialing
 - g. Orientation
 - h. ED staff
 - i. Patient satisfaction
 - j. Consent
 - k. Telephone
 - l. Special patients
 - m. Discharge instructions
 - n. Specific problems
 - o. Test follow-up
6. Optimize superior patient satisfaction by attaining a general understanding of the “do's and don'ts” regarding EM practice
7. Through in an in-depth interactive presentation on EM professionalism, the resident will be able to discuss the following “do's” of EM practice: **DO**
 - make clinical decisions according to the best interests of the patient
 - behave in a manner that enhances patient trust
 - deliver high quality emergency medical care, maintaining the highest level of knowledge and skills
 - listen attentively, maintain confidentiality, and communicate truthfully, respectfully, openly, and honestly
 - be an advocate for the health care needs of emergency patients and the community
 - place the interest and well being of the patient above self-interest
 - work for justice
 - serve as a role model for health care professionals in training
 - work collegially with others, helping to create a productive and effective work environment
- H. Through in an in-depth interactive presentation on EM professionalism, the resident will be able to discuss the following “don'ts” of EM practice: **DO NOT**
 - treat patients or other staff with disrespect
 - misinform the patient
 - document untruthfully
 - overuse power
 - breach privacy or confidentiality
 - cause harm (do not do procedures you are not competent to do)
 - assume anything

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IV. High Risk Complaints and Conditions in Emergency Medicine

- A. Chest pain
- B. Acute Coronary Syndrome
- C. Pulmonary Embolism
- D. Thoracic Aorta Dissection
- E. Abdominal pain
- F. Abdominal Aortic Aneurysm (AAA)
- G. Appendicitis
- H. Headache
- I. Subarachnoid Hemorrhage
- J. Stroke
- K. Pediatric Fever
- L. Meningitis
- M. Airway
- N. Trauma
- O. Head injury
- P. Spinal Injury
- Q. Wounds
- R. Fractures
- S. Testicular torsion
- T. Ectopic pregnancy
- U. Sepsis

V. Operational Risks for the Emergency Department

- A. Facility
- B. Privacy
- C. Equipment
- D. Security
- E. Safety
- F. Credentialing
- G. Orientation
- H. ED staff
- I. Patient satisfaction
- J. Consent
- K. Telephone
- L. Special patients
- M. Discharge instructions
- N. Specific problems
- O. Test follow-up

VI. Confidentiality and the Health Insurance Portability and Accountability Act (HIPAA)

Goals and Objectives

- A. Understand basic concepts of HIPAA and related regulations
- B. Describe basic potential breaches of confidentiality of protected health information and how to avoid them
- C. List elements of protected health information
- D. Describe system mechanisms to protect patient confidentiality

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VII. Emergency Medicine Treatment and Active Labor Act (EMTALA)

A. Goals and Objectives

1. Discuss the intent of the EMTALA legislation
2. Identify providers and facilities governed by EMTALA
3. Give examples of an emergency medical condition (EMC)
4. Describe the purpose of a medical screening exam (MSE)
5. Discharge (admit or discharge to home) ED patients in accordance with EMTALA
6. Evaluate personal and facility documentation practices with regard to EMTALA

B. Content

1. What is EMTALA?
 - a. Original intent (1985)
 - b. Major changes
2. Whom or what providers/facilities does it govern?
3. To which patients does EMTALA apply?
4. What is an emergency medical condition (EMC)?
5. What is a medical screening exam (MSE)?
 - a. What is the purpose?
 - b. Who needs one?
 - c. Who performs the MSE?
 - d. Within what time period must the MSE be performed?
 - e. What is considered part of the MSE?
6. Stabilization of an EMC
 - a. Who must be stabilized?
 - b. What is stabilization?
 - c. Who has the duty to stabilize?
7. Disposition Requirements
 - a. Admission and consultation
 - b. Transfer
 - c. Follow-up
8. Documentation
 - a. Central Log
 - b. Transfer Log
 - c. Medical Record

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VIII. Informed Consent and Informed Refusal of Care

Goals and Objectives

- A. To understand the essential elements of informed consent and informed refusal care
- B. Identify processes of decision making when a patient refuses care
- C. Identify appropriate methods of determining decisional capacity
- D. Discuss the medicolegal risks of allowing patients to refuse medical care
- E. Review the essential elements of documentation of informed consent and informed refusal of care

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IX. Malpractice

A. Goals and Objectives

1. State the definition of "tort" and "negligence"
2. Name the four elements of malpractice
3. Guide professional interactions and documentation to minimize medicolegal risk
4. Identify pre-trial and trial phase events and expectations of the malpractice defendant

B. Content

1. Statistics
2. Tort = a civil wrong, whether intentional or unintentional
3. Negligence -> professional negligence -> malpractice
 - a. Negligence definition
 - b. Elements: duty, breach of duty, harm, causation
 - c. Contributory negligence
 - d. Comparative negligence
4. Why do people sue?
5. How to avoid lawsuit?
 - a. Be nice
 - b. Documentation

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6. What to do if sued?
 - a. Basics
 - b. Timeline
 - c. Deposition
 - d. Testimony

X. Research

A. Goals and Objectives

1. Understand basic types of research design
2. Name the important areas of research in risk management issues
3. Identify potential barriers to risk management research

B. Content

1. Evaluating a Medical Study
2. Study Design
 - a. Observational
 - b. Experimental
 - c. Decision analysis
 - d. Meta-analysis
3. Design Features
 - a. Randomization
 - b. Blinding
 - c. Controlling variables
 - d. Sample size
 - e. Power calculation
4. Understanding Basic Statistics
 - a. Sensitivity and specificity
 - b. Likelihood / Odds ratios
 - c. Pre-test and post-test probability
5. Resources
 - a. Peer reviewed journals
 - b. Literature search tools
 - c. Consensus/policy statements / Guidelines
 - d. ACEP
 - e. Other specialty organizations
 - f. Malpractice insurance carriers (e.g. Risk Management Foundation)

C. Operational Risk Management Research

1. Malpractice issues
 - a. Closed claims studies
 - b. High risk diagnoses
 - c. Reasons for suits
2. Medical errors / Patient safety
 - a. History of accident analysis: industrial disasters (Piper Alpha Platform disaster 1988)
 - b. “Human Factors” analysis
 - c. Critical incident / root cause analysis
 - d. Team dynamics / communication
 - e. Patient / scenario simulators

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3. Areas that need further research
 - a. Documentation
 - b. What is a defensible chart?
 - c. Predictors of malpractice suits
 - d. Successful strategies for avoiding / managing suits
 - e. Training strategies for reduction of errors
 - f. Does adherence to guidelines protect against malpractice?
4. Barriers to research
 - a. Long life-cycle of malpractice cases
 - b. Under-reporting of incidents
 - c. Lack of standard definitions / measures

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Developed by the Academic Affairs Committee
December 2005

Catherine A. Marco, MD, FACEP, Subcommittee Chair
Thomas E. Syzek, MD, FACEP, Medical Legal Committee
Charles J. Gerardo, MD, FACEP
Jennifer Casaletto, MD
Lynn P. Roppolo, MD, FACEP
Michael Woodruff, MD

John J. Kelly, DO, FACEP, Chair
Sandra M. Schneider, MD, FACEP, Board Liaison

Acknowledgments

The authors wish to thank members of the ACEP's Academic Affairs Committee and Medicolegal Committee for providing valuable insights and contributions to this document.

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Appendix A

So You've Been Sued!

This resource is designed to provide general, preliminary guidance in regard to the subject matter covered. It is provided by the American College of Emergency Physicians (ACEP) and used by the reader with the understanding that ACEP is not engaged in rendering legal, psychological, medical, or professional services. If expert assistance or counseling is needed, the services of a competent professional should be sought.

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A. Introduction

If you are reading this, you probably have received notice that you have been named in a malpractice suit. Welcome to a distinguished group of your peers! It is the rare emergency physician who will not be sued during her or his career. During the course of your suit there will be many personal, professional, financial, and legal issues you will face. There are numerous articles, web sites, books, and organizations offering worthwhile advice on how to survive a medical malpractice lawsuit. Some of these sources will be referenced later. This article is intended to be a practical resource to help you navigate the best possible course through the uninvited and unwelcome process of malpractice litigation. While it is the goal of ACEP to provide support and general guidance, legal advice and representation can only come from your attorney.

B. Let's start first with the basics.

1. Are all notices from an attorney a lawsuit?

No. An attorney letter may be a simple request for medical information or medical records. Even if it is only a letter from an attorney requesting information, be careful! Do not express opinions that are not already contained in the medical record and do not express opinions about the care and treatment of other treating physicians. It is best to check with your risk manager, insurance company or (if you have one) your defense attorney prior to responding to any correspondence from a potential plaintiff attorney.

Other letters may be a legal notice of intent to sue. These letters are sent in order to extend the statute of limitations by a certain statutory period. These notices are normally forwarded by certified mail and will indicate that the patient is considering a suit against you.

And, finally, the 'letter' may be a lawsuit!

2. What is a lawsuit anyway?

In the legal system, the formal name for a lawsuit is a 'complaint.' The complaint will state the name of the patient (plaintiff) and the doctor(s) and hospital(s) called the 'defendants.' The law requires that a complaint be a short and plain statement of the facts which form the basis of the claim against you. However, many times it will be difficult for you and your attorney to figure out the theory of plaintiff's case against you until your lawyer is able to formally question the plaintiff and the plaintiff's expert.

The complaint is supposed to state how you fell below the standard of care when providing medical treatment for the patient; how that failure of medical treatment caused injury to your patient; and, what damages directly resulted from the breach of the alleged standard of care.

In many states, the amount of an award for damages will be limited. On the other hand, in most complaints the damage claim demand will be potentially unlimited. You cannot depend that the damages requested in the complaint are the limit of what is really being requested.

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All notices and complaints should be immediately forwarded to your insurance agent and/or insurance company. Never fail to send an “intent to sue letter” or a formal court complaint to the insurance agent and/or insurance company right away! You must formally respond to a claim within a certain time limit, or a default judgment will be taken against you. Furthermore, if you have a “claims made” liability policy, your notice of the existence of any type of claim can be critically important in determining whether or not you are covered. Notification of your insurer should occur as soon as you receive any indication of a possible or pending claim, and it is advisable to secure proof that it has been received (e.g., certified letter, return receipt requested).

3. How does a civil suit differ from a criminal suit?

In a criminal case, you can lose your freedom. In other words, you can be put in jail for a criminal act which leads to a conviction. In addition, there can be a criminal fine along with jail time. Criminal claims are normally prosecuted by the state attorney general, county prosecutor or a municipal prosecutor. The state, county or municipality will usually be the complainant/plaintiff and the alleged criminal will be the defendant.

On the other hand, civil suits can only result in money judgments or money damages. In civil cases, private attorneys are retained by the patient or the estate of the patient to file a civil complaint and, unless self-insured, the case will normally be defended by an attorney selected by your insurance company.

4. What are the basic steps of the litigation process?

As previously stated, the case begins with a complaint filed in court. The complaint will end up in the hands of your lawyer and s/he will file an answer on your behalf. You will receive various requests for “discovery” of information, in the form of questions (interrogatories) or demands for documents from the plaintiff, and your lawyer will also be sending questions and document requests to the plaintiff’s attorney.

After there have been responses by both sides to the interrogatories and document requests, depositions of the parties (testimony under oath) will be scheduled. Normally, this will be done at the convenience of the parties and the lawyers. Your deposition will probably be taken at your lawyer’s office and the deposition of the plaintiff will be taken at the office of the plaintiff’s lawyer. Your deposition will be the most important involvement by you until trial. If you have gone through the deposition process on prior occasions, one preparation session may be all that is necessary. On the other hand, if this is your first lawsuit, it may take several conferences with your attorney to get properly prepared. At times, you may be videotaped so that you can see how you present yourself.

Your attorney will also seek your input and assistance on expert selection. In order to prosecute a medical malpractice case, each side will identify medical experts, normally in the field of the alleged injury. However, in certain emergency medicine cases you may identify experts in different specialties. For example, in a case involving a delayed diagnosis of an impending myocardial infarction, you may have as many as three medical experts which would include: 1) an emergency physician, 2) a cardiologist, and 3) a pathologist. Normally, it is difficult to evaluate the strengths and weaknesses of a case until after the expert witnesses have been deposed (made statements under oath).

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In some cases, something called a “Motion for Summary Judgment” will be filed on your behalf. The intent of this motion is to cut the proceedings short. This may occur when the other side is unable to produce a competent expert. However, very few cases are disposed of by way of motions.

In the past ten years, there has been a big push by the courts for alternative dispute resolution (ADR). This may include non-binding arbitration or mediation. Some courts force ADR, but the court cannot force you to settle. In some circumstances, the court may appoint the arbitrator and/or mediator. In other cases, the parties may get together to jointly hire a mediator to assist the parties to an ultimate resolution. The fact that a case is arbitrated or mediated does not necessarily mean that a successful settlement will be achieved or that the case should necessarily be settled. Many arbitrations/mediations do not result in settlement and the case will then proceed to trial.

The trial will be attended by you and your attorney. You will need to be there during the entire trial. Medical malpractice trials typically run from one to three weeks.

5. How long does the process usually take?

In most states and most courts, a trial will be scheduled within a year after the filing of suit. In courts that are run efficiently, a trial may be scheduled in less than six months from the date of the filing of the complaint. There are extreme ranges depending upon the state and locale, as well as the zeal of the attorneys to process the case. The range can run from less than a year to as much as four years or longer.

6. What are the possible outcomes of my suit?

After the complaint is filed, many cases are voluntarily dismissed by the plaintiff’s attorney. Why does this happen? Frequently, the attorney does not get the case until just before the running of the statute of limitations. The attorney will file the suit and then send it out to an expert. On some of these occasions, the expert will tell the attorney that his client does not have a case against you. This may result in a voluntary dismissal. Sometimes, the case will be voluntarily dismissed by the plaintiff’s attorney because they are not ready to proceed, and if allowed by the statute of limitations, it can be refiled, normally within a one year period. Sometimes, the court will dismiss the case with prejudice for lack of prosecution by the plaintiff. As stated above, some cases will be dismissed by the court on summary judgment if the plaintiff fails to produce a competent expert to say that you did something wrong in your care and treatment of the patient.

Other cases will result in settlement. Settlement is a legal maneuver which allows for a case to be terminated without a trial, usually on payment of a certain amount of money to the plaintiff. In general, you will have a right to ‘consent’ or ‘refuse to consent’ to settlement. Most insurance policies give you this right, though not all. It is important to know your policy on this point, preferably before a suit is brought! Normally, there will be a little disagreement between you and your attorney as to whether a case should be settled or go to trial.

A ‘verdict’ means that the case has gone to trial and the jury has made a decision. The verdict is the jury’s decision as to whether or not you met standards of care or fell below standards of care; and if you fell below standards of care, whether you caused an injury; and finally, the amount of the money damages which will be paid as a result of the injury.

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7. What should I do with the legal papers I receive?

You should immediately notify your insurance agent or the insurance company. If you are with a self-insured group, you should immediately contact risk management for your group. You should also mark your calendar to follow up and make sure the legal papers are being promptly handled by the insurance agent, insurance company, or risk management.

Do not depend on your office staff to properly handle the legal papers. **Do not** put these legal papers in the same stack as other reports and correspondence. Failure to properly respond to a civil complaint can result in a default judgment against you. In turn, this could cause your insurance company to refuse to defend you and refuse to pay for any judgment. In addition, a default judgment means that you cannot even defend yourself on the issue of whether or not you did something wrong!

8. Should I keep the original or make copies?

Generally, I would make a copy and send the original to the agent, insurance company, or risk manager. However, in today's world, there is little difference between an original and a copy of a civil complaint.

9. What should I do first when I receive a legal notice or correspondence?

Immediately forward the legal notice or correspondence to the insurance agent, insurance company, or risk manager.

10. Who should I contact?

Contact risk management for your group and at your hospital and your insurance carrier as soon as you receive any indication that you are going to be sued (such as a subpoena, a request for records, or a claim). When a claim is actually received by your insurer, you will be assigned a lawyer to help you with your defense. The more time you can provide to your lawyer and risk manager, the better able they will be to help you with your case, and the better job they can do on your behalf.

11. Who will assign my defense attorney?

Normally, you will have little or no input in the assignment of your defense attorney. Your insurance carrier will make this assignment. However, you may know the more experienced defense attorneys in your area. If they are willing to work for your insurance company, your request to be represented by one of them may be honored by the insurance company.

12. Will my defense attorney contact me, or do I call him/her?

Your defense attorney will normally contact you by letter, telephone or both.

13. What if I am not satisfied with the attorney selected?

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Many times after receiving a claim which says that you fell below the standard of care you will be upset, hurt, and possibly even ready to quit the practice. Give yourself some time to calm down, learn the true facts of the case, and become acquainted with your selected attorney.

Get to know the attorney's personality and ability to represent you. If you have concern with the attorney's representation, express that concern immediately with the attorney. If the personality conflict or dissatisfaction with representation continues, call the insurance carrier who appointed your attorney and strongly express your concern. Before doing so, however, be sure your frustration is with the attorney representing you and not due to the fact that you have been sued. Usually, the insurance company will appoint new counsel if your dissatisfaction is justified.

14. What if there is an apparent conflict between my attorney and someone else in the case?

Conflicts can be handled several different ways by your attorney. First, if you feel there is a conflict, you need to discuss it with your attorney. Often times, the attorney will represent more than one doctor in the case. For example, on repeated emergency room visits within a short period of time, several doctors may be involved. Generally, it is better to have one attorney representing all of the physicians, especially if they are all within the same specialty and the same group and there is no real negligence involved on the part of anyone. However, if you feel that your interests are best served by separate counsel, you must express your opinions to both the attorney and the insurance company. Representation will then be split and a new attorney will be appointed either for you or the other doctor.

15. What can I tell my attorney?

Tell your attorney everything you know about the case. Anything that you tell your attorney is privileged and cannot be disclosed to any third party by your attorney. This is known as the "attorney – client privilege." You should definitely tell your attorney about any 'problems' that may exist regarding your care and treatment. Also tell your attorney about any problems you feel may exist regarding other caregivers.

16. Who can I talk to about my suit?

Don't discuss the details of the case with anyone except your lawyer, your spouse or a counselor. You may discuss your feelings about getting sued, but not the details of the case. Discussions with anyone else can be discovered by the plaintiff's lawyer. When asked by the plaintiff's attorney under oath if you discussed the case with anyone, you want to be able to answer, No. You don't want friends and colleagues to be dragged into court to testify about what they recall you told them about the case.

17. Can I participate in selection of the defense expert?

Absolutely. However, the selection of the defense expert cannot be a friend, relative, or someone with whom you have regular contact. The defense expert must be truly 'independent.' Expect your attorney to ask you if there is someone that you have in mind who is a leader in your field with quality credentials and medical/legal experience. If s/he doesn't ask, volunteer. Remember, this is your case. You should participate with your attorney in your defense from beginning to end.

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18. Are Peer Review documents protected?

Yes. In most states, Peer Review documents are protected by statute. This protection is necessary since open and honest discussion is required in Peer Review. Occasionally, the other side will seek to obtain Peer Review documents. On rare occasion, the court will order that the Peer Review documents be examined 'in camera.' This means that the court will look at the Peer Review documents without the attorneys or parties.

Peer Review documents are almost always protected as long as they have not previously been voluntarily disclosed to third parties.

19. Something important was left out of the patient's medical record. Can I change or add something now?

Don't alter your medical record. Don't go back and change the record in any way. Changes can always be detected, and if that happens, your credibility will be in serious question. Without credibility, you do not have a defense. However, you can make a careful note of what was left out or incorrect, and add it as an addendum CLEARLY labeled as such and dated as of the writing (not the clinical interaction). Check with your attorney to see if an addendum would be advisable at this late date, or could be misinterpreted. Have the attorney review the addendum if it is advisable.

20. Can I just call the patient, the patient's family, or the plaintiff attorney to explain what really happened?

Don't call the plaintiff or the plaintiff's attorney to see if you can simply explain what happened so that the suit will go away. It is too late for this. What you say may be used against you, later.

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C. Now let's consider some questions about financial issues.

1. For what expenses is my professional liability insurance company responsible?

Depending on the language of your insurance contract, the insurance company typically pays the defense costs, any settlement or judgment payments, and sometimes compensation for your time spent during trial.

2. Is there anything the insurance company will not pay for?

Again this depends on the details of your insurance contract. Usually malpractice insurance companies do not reimburse you if you hire your own personal attorney, or for full replacement of your income lost during the litigation process. They will also not pay for monetary awards which exceed your policy limits, or for punitive damages.

3. What happens if the judgment does exceed the limits of my liability insurance policy?

First, this rarely happens. Whether you are responsible for excess awards depends on the circumstances and conduct of your insurance carrier. If you ask the insurance company to settle this case within the policy limits before judgment and they refused, you probably have a bad faith action against your insurance carrier for failing to settle within the policy limits.

Second, in the rare case that the judgment exceeds the policy limits in which you and your attorney thought you would win, you can still attempt to negotiate a settlement with the other side recognizing that any money paid in settlement above the policy limits will be yours. Bankruptcy is also an undesirable option.

Judgments which exceed the policy limits are exceedingly rare, as are cases in which the physician is required to pay any money out of his/her own pocket.

4. When should I consider hiring my own personal attorney?

You should hire your own personal attorney when it appears your case is going to trial and that there is a reasonable likelihood of a verdict in excess of your policy limits. In those cases, you should definitely hire your own personal attorney to review the case and make an independent determination as to your personal monetary exposure. You should also consider hiring a personal attorney if it appears that you are receiving ineffective assistance of counsel from the insurance company attorney, and the adjuster refuses to allow you to change attorneys, or if you need someone other than the insurance company retained attorney to negotiate with the insurer.

5. Will my insurance company pay for an EMTALA violation?

No, your liability (malpractice) insurance company will not pay for fines, settlements, or financial judgments which result from an EMTALA violation. Most insurance contracts will not pay for any judgment relating to allegedly illegal behavior. However, in some instances they will defend you, but seek payment from you if you are found guilty of such conduct. Read your contract carefully to determine whether such defense coverage is available. Some licensure actions may be defended by liability carriers if relating to an alleged malpractice claim.

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D. Here are some common questions addressing the repercussions when you settle or lose a malpractice lawsuit.

1. What happens if I settle or lose my lawsuit?

Although there are many repercussions to settling or losing your lawsuit, unless there are also criminal charges you will not go to jail! Remember, this is a civil lawsuit in which only money damages will be paid to the claimant by way of settlement or verdict. Once the settlement amount has been negotiated and agreed upon or the damage verdict has been rendered by the jury, your involvement is basically over.

The insurance company will pay the settlement in exchange for a dismissal of the lawsuit and a release of all claims against you. In the event the case proceeds to trial and the jury renders a money damage verdict which is within your policy limits, your attorney and the insurance company will decide whether to appeal or pay the verdict.

2. Who is notified about my settlement or loss?

In the event of settlement, regardless of the amount (unless you pay it all yourself), the National Practitioner Data Bank (NPDB) is notified of the nature of the case and the amount of the settlement or loss.

In many states, if the settlement or loss is over a certain amount, the State Medical Board is also notified. In the event of a number of settlements or losses within a designated period, the State Medical Board may decide to investigate your medical practice.

3. Who reports me to these agencies?

Under normal circumstances, your insurance carrier will report you to the NPDB or State Medical Board. Sometimes you can influence the wording of this report before it is sent. This should be investigated immediately upon any settlement or judgment. If you are practicing within a self-insured group, the representative of risk management of that group will have the responsibility of reporting.

4. Can I contest or make any statement about my case?

Yes, you can contest or request to make a statement about your case. By law, you will receive a copy of the report forwarded to the NPDB. You are allowed to supplement that report or argue that the report is incorrect.

5. If I settle or lose my case, will I lose my license to practice?

No. However, you may be subject to an investigation by the State Medical Board in the event you have a number of settlements or losses within a designated period of time or in the event that a patient makes a complaint.

6. What will this mean to my insurance carrier?

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Insurance carriers profit from collecting premiums. They do not like to pay settlements or judgments! However, you have certain contractual rights with your insurance carrier and they must comply with the insurance contract while you are an insured. Your insurance carrier will review internally whether or not they wish to keep you as an insured after expiration of your policy.

7. What is likely to happen to my insurance premium rates?

Your premium rates will certainly go up. This will be dependent upon the amount of the settlement, the current economic strength of your carrier, and other world events outside of your control.

8. What information and records regarding my case should I save?

As distasteful as it may be, you should save the complaint, settlement documents, release, and, if the case goes to trial and is lost, the verdict and judgment entry.

9. What information should I disclose when I apply for insurance and hospital privileges in the future?

You will be asked questions regarding all past lawsuits. You will need to disclose these lawsuits and how they ended, i.e., dismissal, settlement, or verdict. More or less details may be demanded.

E. The following discourse addresses common questions about your preparation for the legal process.

1. What should I read, if anything, in preparation for my testimony?

Do be an expert about your case and the associated medical literature by the time of your trial. How much expertise you acquire before your deposition is something to discuss with your lawyer. As a general rule, you do not want to educate the opposing attorney during your deposition. Yet you need to be knowledgeable about the condition in order to educate your own attorney in preparation for the case. You want to be a knowledgeable witness for the jury in your defense. If the plaintiff's lawyer asks you in front of the jury if there is anything new in the treatment of X, Y and Z, you want to be able to mention that NEJM article from 3 months ago on the subject. You want to help your lawyer understand the case. If asked whether you did research or reading to prepare for the case, you of course must answer truthfully. But if asked if what you read is authoritative or reliable, the answer is a resounding "No." You should testify that you use medical literature simply as a reference. This is because the plaintiff's lawyer will then quote something from what you read that is not beneficial to your case, and attempt to portray you as not complying with your own "authorities." Any author can be right or wrong about any given issue.

2. How familiar should I be with the medical records of my case?

VERY familiar. In fact, you should be the most knowledgeable person in the case regarding the medical records. The reason for this is that the jury will often equate your knowledge of the case and your concern with the details with your care and concern for the patient. If you are not fully aware of all the details, the opposing attorney will be sure to plant the idea in the jury's mind.

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You should also ask your attorney if he has any medical records of prior or subsequent medical care and treatment. Ask your attorney if he will prepare an indexed book of medical care and treatment of the patient so that you can take it home and review it when you have time. Knowledge is power. Therefore, the more familiar you are with the medical records of the case, the more comfortable you will be at the time you are questioned regarding your care or the care of other health care providers.

You do not have to memorize the medical records. They will always be available to review at the time of your discovery deposition or trial so that you can assure the accuracy of your testimony.

3. When and how often should I meet with my defense attorney?

There should be an initial meeting with your defense attorney shortly after the case is filed. At this meeting, you can get to know each other and generally discuss the case.

After the initial meeting, most of the discussions can take place over the telephone until you are being prepared for your discovery deposition.

Many times, the number of meetings is based both on your experience with litigation and the complexity of the case. Your attorney will always be willing to meet with you when needed. Do not think you are a pest by asking for a meeting.

4. How should my defense attorney best prepare me for my deposition and trial testimony?

Your attorney should spend all the time you feel that you need in preparation for your appearances. S/he should educate you not only to the process and likely questions to be asked, but also as to your dress, demeanor, and any particular pitfalls to avoid during testimony. Also what to bring with you to the proceeding, and what NOT to bring. And s/he should be willing and able to give you feedback about what kind of a witness you will make in your own behalf, how you can improve your performance, and how to practice. If the attorney is unwilling or unable to provide you with as much preparation as you would like, it can be valuable to procure a consultant who can provide professional “depo prep” in conjunction with your defense attorney.

The main difference between preparation for your discovery deposition and preparation for trial testimony is the fact that you will be able to correct your past mistakes when preparing for trial testimony. By the time you prepare for trial testimony, you will not only have read the medical record, you will also have reviewed and re-reviewed your discovery deposition; the depositions of your expert and the opponent’s expert; and, any other discovery depositions. You will be totally familiar with all of the medical issues. You will normally be asked to be present during the entire trial which will usually take between one and three weeks, depending on the type of case.

5. What is my role during my deposition, or testimony at trial?

At deposition, you are the ‘star of the show.’ You will receive little help from your attorney since he/she cannot tell you what to say. All this will have been done during preparation sessions.

At trial, your attorney will do most of the work but you will get your input. The team approach works best. You may make suggestions for questions. Involve yourself as much as possible.

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6. Are juries influenced by how I look, talk, and act?

Absolutely. Dress is important and your attorney will probably ask you to wear business attire. Your demeanor is critical. Arrogance is the kiss of death. Your attorney will tell you more than once to look the jurors in the eye and talk to them--not as doctors but as people.

F. There are likely to be personal issues which arise during the course of your suit. These are common issues to acknowledge and deal with in a constructive manner.

1. What might I feel during the early stages of my suit? Right now I am shocked and can't believe they sued me!

You will feel shock, anger, disbelief, anxiety, and very possibly depression. You may very well experience physical as well as psychological symptoms. Be aware that some of these feelings will very likely spill out into your ongoing patient interactions. Evidence suggests that your likelihood of being sued again in the immediate aftermath of being served with a suit is quite high, probably based upon some of these behaviors. You will likely begin to practice more defensive medicine, and distancing yourself from patients who can be perceived as future litigants against you.

2. I hear the suit may drag on for years! What am I likely to experience emotionally over time?

The average suit is not resolved for up to four years. Suits tend to progress in stages, with fits and starts as deadlines are missed, events rescheduled, and new information is revealed. Each time you revisit the case after a period of quiescence can be like a vicarious retraumatization, bringing back a bit of the initial shock and anger.

3. Who can and should I talk to?

Strongly consider seeking emotional support from another physician who has been sued. A malpractice suit is a very difficult emotional experience for physicians—one of the deepest personal and professional threats you can experience. Don't underestimate its possible negative impact on your professional life and emotional well being.

4. Are there ACEP members I can talk to during the course of my suit?

ACEP has compiled a list of physicians who are willing to be available for brief emotional support. Peers are not a substitute for professional help, but they can be enormous sources of comfort and reassurance that this experience is eminently survivable. Call Marilyn Bromley a t ACEP for a referral.

5. I think I am getting depressed, anxious, or panicky. When should I get professional help?

There is perhaps no more appropriate reason for a physician to seek professional help than being faced with a malpractice suit. If fear or rumination about the case is beginning to impact your personal or professional life, it is time to reach out for support. If sleep, appetite, weight, or pleasure seeking activities are being affected, it could be critically important to seek intervention. Early counseling can be lifesaving.

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Listen to your family. They are often more attuned to the effect a case is having on a physician than the physician.

6. How will my family generally react to me during this stressful time? What can they and I do to get through this as a family?

Your family will not at first understand what is happening. If the case is being “tried in the press” they may even hear about it first from a highly unreliable source, or from someone other than yourself. Make it a point to sit down with them as soon as you know a case is pending and explain to them why you believe it is happening, what it means, and how they can help you to get through it. Don’t share details about the case except with your spouse. But you can explain in generalities, and allay their fears that the worst will happen to you or that you are a bad doctor.

7. How important are diet, relaxation, exercise and other wellness techniques?

More important now than at any other time in your professional career. Prescribe a certain number of hours of sleep for yourself, and schedule recreation and down time just as you would clinical shifts. Pamper yourself with nutritious, satisfying foods and social occasions on which to enjoy them with people you care about.

8. What can I do to help deal with the anxiety associated with depositions or trial testimony?

Get as much preparation as you can, and practice with a professional and/or with a video camera. Use affirmations daily. What is an affirmation? Look into your mirror each morning and say with conviction, “I am a competent and caring professional and it shows in everything I do.”

Because you are, and it does.

9. After it’s over, what can I do?

Congratulate yourself on surviving one of the most predictable, yet least anticipated events in the life of any physician. Investigate asset protection, and learn and practice immaculate risk management principles. Seek out others who are experiencing this for the first time, and be a healing influence for them.

G. References:

Litigation Stress

<http://www.acep.org/>

Getting Sued: A Resident's Perspective

<http://www.acep.org/>

Managing Malpractice Stress

<http://www.magmutual.com/>

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Coping with Litigation Stress

<http://www.physiciansnews.com/>

Preparing for Your Deposition By Raymond M. Fish, MD, Ph.D., available from ACEP bookstore

Preventing Malpractice Lawsuits in Pediatric Emergency Medicine By: Korin Selbst, ACEP Bookstore

General Information on the Litigation Process, Discovery, Depositions, and Trials

<http://www.thesullivangroup.com/>

Additional resources, self test for litigation stress, and references

<http://www.mdmentor.com/>

Resource Document Developed by ACEP's Medical Legal Committee

Thomas Syzek, MD, FACEP, Work Group Chair

Louise Andrew, MD, JD, FACEP

Neil Freund, JD, John Bibb, MD, FACEP

Daniel Sullivan, MD, JD, FACEP