THE SULLIVAN GROUP

TSG Quarterly Report

At the crossroads of law and medicine

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Emergency Medicine Malpractice Case Reporter

Overview

Efforts to stem the tide of medical errors and litigation related to "Failure to Diagnose Myocardial Infarction" have failed. The thought process applied to chest pain cases is often flawed, and in direct opposition to well-accepted evidence based clinical management. Despite training, board examinations, peer review and other methods of driving home the message, the same mistakes continue to rear their ugly heads.

Case Review

Subject: Failure to Diagnose Coronary Artery Syndrome

A 40 year-old male recently presented to a twenty-four hour immediate care center. He arrived at 1250 and was triaged at 1255. Initial vital signs: pulse 82; respiratory rate 24; blood pressure 224/118; pulse ox was 98% on room air. Pain scale was 6 out of 10. The nurse checked the box that indicated that the patient smoked cigarettes.

The patient told the triage nurse that while at work he did not feel like eating, he began sweating and developed umbilical and epigastric discomfort. Patient was unable to move his bowels that morning. Patient arrived at triage diaphoretic. Alert and oriented times 3. Patient was feeling a little better than he did at work.

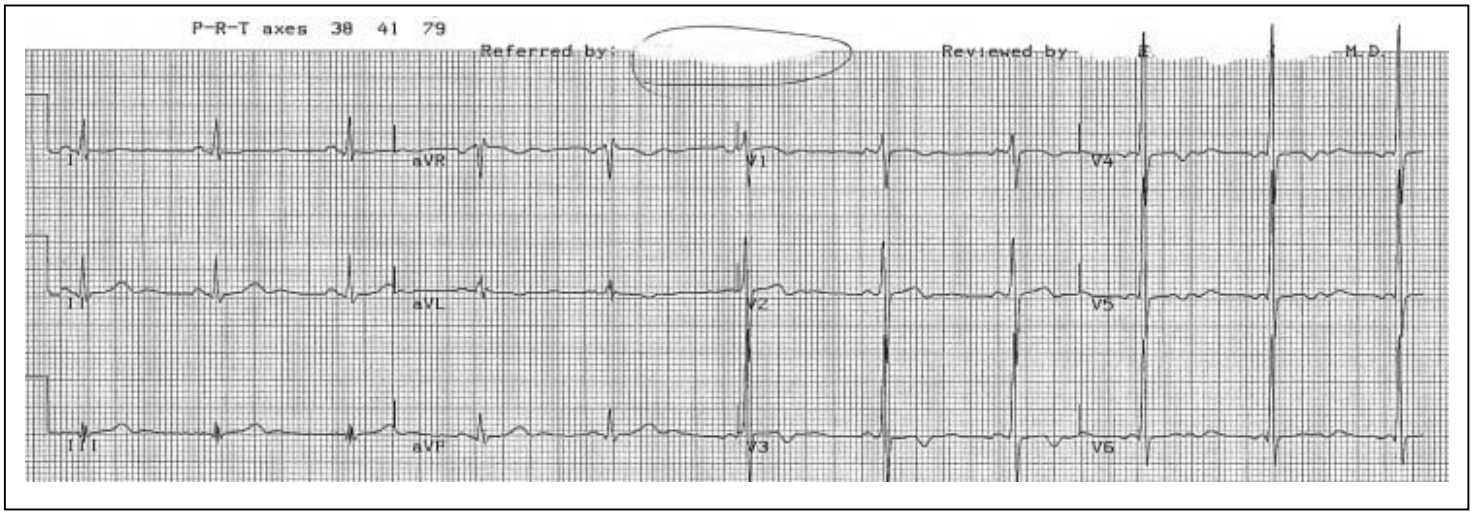
The physician on duty was a board certified, residency trained emergency physician. He saw the patient within a few minutes after triage. History of present illness: The patient complained of epigastric and supraumbilical abdominal pain, associated with diaphoresis. Patient denied chest pain, shortness of breath and there was no left arm pain. There was no vomiting or diarrhea. No history of chest pain on exertion. Maximum and current severity were "moderate."

On review of systems there was abdominal pain. No nausea or vomiting. No constipation. No melena. The rest of the review of systems was unremarkable. The patient denied past medical or surgical history, and denied drug, alcohol and tobacco abuse.

On physical examination, patient was comfortable, alert and oriented times 3. Heart and lung exams were normal. On abdominal exam, no masses, bowel sounds normal, mild tenderness in epigastric area. No peritoneal signs. The remainder of the physical examination was unremarkable.

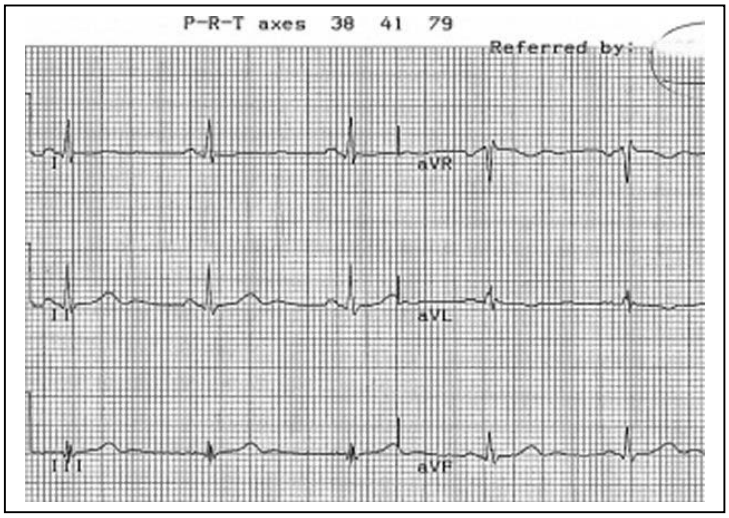
The physician ordered a cardiac profile, complete blood count and basic metabolic profile and an ECG. See Figures 1, 2, and 3 to review the 12 lead ECG, limb leads, and chest leads. What is your interpretation of the ECG?

Figure 1. 12 lead ECG



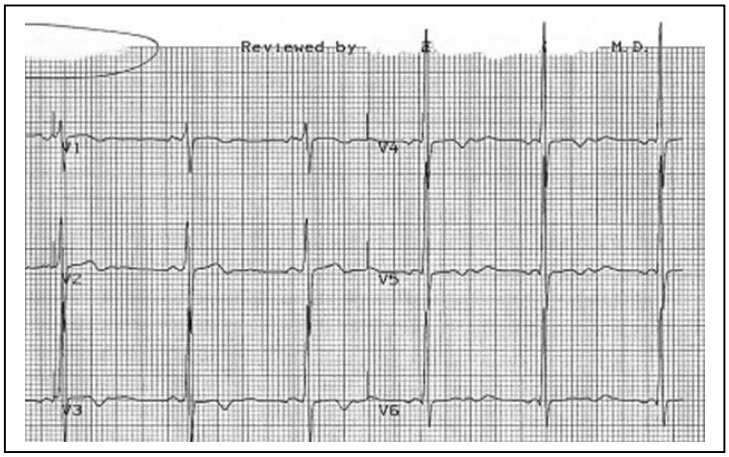
Now take a closer look at the limb leads.

Figure 2. Limb leads.



Now take a closer look at the chest leads.

Figure 3. Chest leads.



The physician ordered sublingual nitroglycerin at 1305. He noted "no effect." He ordered another dose of sublingual nitroglycerin at 1325. He again noted "no effect." At 1340 he ordered a GI cocktail and Tylenol. The physician noted "symptoms resolved."

The troponin, myoglobin and CPK-MB were within normal limits. Complete blood count and electrolytes were normal. Repeat vital signs revealed a pulse of 74, respiratory rate of 20 and a blood pressure of 170/115.

Following the GI cocktail the physician noted, "Given GI cocktail, patient reports immediate, lasting, total relief of symptoms. Differential diagnosis was "Acute Gastritis." Patient was discharged home in good condition with a prescription for Prevacid and a request for a follow up with a private physician and an order for an outpatient stress test.

The following day, the ECG was overread by a Cardiologist, and the ECG and medical record were placed next to the immediate care physician on duty the next day as part of the normal routine. That physician reviewed the record and the ECG, and became concerned regarding case management. He immediately called the patient's home and reached the patient's father. The father stated that his son was staying at a friend's house overnight, but did not go to work because he was not feeling good. The physician asked that the son call back to the immediate care center if the father should hear from him.

The son called back about three hours later. The physician spoke with him on the phone and asked if he was calling from his home. In fact, the patient was calling from a stretcher space in an emergency department where he presented with chest pain, a severe headache and severely elevated blood pressure. The patient was on his way to the cath lab. Later reports indicate that the patient had severe stenosis in his anterior descending artery. Calamity avoided!

Discussion

1. **Failure to Diagnose Coronary Artery Syndrome.** This patient presented with epigastric and umbilical pain, diaphoresis, two major risk factors (smoking and hypertension) and an abnormal ECG. That is plenty of information to decide that this patient needs management for possible unstable angina and further diagnostics. How much more obvious can a case get? This is substandard and indefensible care.

2. **Don't let the GI Cocktail screw up your thinking!** This physician was clearly thinking about coronary artery disease, until he gave the GI cocktail. Then all his education about atypical pain, cardiac risk factors, abnormal ECGs, and everything that could properly direct his thinking all flew out the window. The patient responded

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to a GI cocktail and coronary artery disease falls off the differential diagnosis. Even plaintiffs' attorneys are now aware that the patient's response to a GI cocktail is not a basis for decision-making in a patient with possible coronary artery disease. In any risk stratification algorithm, this patient gets admitted to the hospital.

3. **The ECG.** The computer reading on the ECG was: "Normal sinus rhythm. ST & T wave abnormality, consider anterolateral ischemia. Abnormal ECG." Although the ECG computer interpretation software is far from perfect, this physician overlooked or ignored a key piece of information. It just seems inconceivable that any patient could be discharged home given this fact sequence.

4. **RN-MD Discrepancy.** The nurse noted that the patient smoked. The physician noted that the patient did not smoke. The patient did smoke. The physician would be dead in the water during deposition or at trial. This is an obvious mistake. Both physician and nurse should make every effort to make sure there are no discrepancies on the medical record. Take the team approach in high-risk acute care. The nursing documentation is critical.

5. **Blood Pressure.** The patient was discharged with a blood pressure of 170/115 with no apparent prior history of hypertension. On discharge, there was no indication that the patient should follow-up for blood pressure evaluation. There was no timing of the follow-up to make sure the patient's blood pressure and other problems were addressed in a timely manner.

6. **Outcome.** Tragedy was avoided in this case. It clearly could have gone either way. Let this case serve as yet another warning about medical errors and patient safety. This is not acceptable patient management. However, this was a common fact sequence 10 years ago, 5 years ago, and it continues today. ♦

For more information about the failure to diagnose Coronary Artery Syndrome and other High Risk Emergency Department clinical entities, see the Core Curriculum on Risk and Error Reduction in Emergency Medicine on the TSG home page at www.thesullivangroup.com.

Special Issue

Defamation

What is Defamation?

Defamation constitutes an oral or written communication to a third party of false information that injures his or her reputation by diminishing the esteem, the respect, or confidence in which the person is held or by exciting adverse or derogatory feelings against the person. Such a communication made orally constitutes slander; if written, the communication constitutes libel.

Defamation suits against physicians are relatively common, and in retrospect are usually completely avoidable. A common defamation case is the inappropriate release of medical information. Truth is an absolute defense, and although the patient's reputation may be injured by the content of the medical information, by and large that information is truthful. Thus, the lawsuit must fail.

The following examples are state specific to Iowa, Georgia, New York, and Alabama. TSG will provide you with an overview on defamation at the end of these examples.

CASE EXAMPLE 1 – Physician vs. Administrator

King v. Sioux City Radiological Group, P.C, .985 F. Supp. 869 (decided Nov. 20, 1997).

Plaintiff worked as the Technical Director of Radiology at St. Luke's, an administrative, non-physician position, from mid-April of 1990 until he was terminated effective January 31, 1995. Plaintiff was responsible for technical and support staff and equipment within the radiology department, while Sioux City Radiological Group "SCRG" and its doctors provided the medical services in the department.

During 1993, Plaintiff's relationship with the doctors in the radiology department became strained. Plaintiff alleges that he had attempted to address rumors about a supposed extra-marital affair between one of the doctors and a radiology technician, and complaints about favoritism of that doctor towards that technician, inappropriate behavior and horseplay between the two in the workplace, and alleged poor treatment by that doctor of other staff members. SCRG contends that the tension arose from

Plaintiff's attempts to exploit groundless rumors about an affair between one of the doctors and the radiology technician to his political advantage within the department and from King's failure to perform his job adequately.

Matters came to a head, not for the last time, in November of 1993, when the leadership of the radiology department changed hands and the radiology medical director's position became available. On November 1, 1993, one of the other doctors of the radiology group approached a candidate for the position and told him that he would become the medical director of radiology, but only on the condition that Plaintiff be terminated. One of the reasons that doctor gave for this condition was his distaste for the way in which Plaintiff had handled the rumors concerning the supposed affair between that doctor and the radiology technician. The candidate declined to fire Plaintiff, and so informed the doctor on November 17, 1993. Another doctor eventually became the medical director of radiology.

Matters boiled over again in April and May of 1994. On May 11, 1994, the doctors of the SCRG group had a meeting and aired a number of complaints concerning Plaintiff. At that meeting, the doctors also specifically requested that Plaintiff be terminated. A letter detailing the doctor's complaints was produced as a result of that meeting. This letter forms the basis for Plaintiff's defamation claim.

The letter details seven "concerns" regarding Plaintiff, which involve the following:

(1) …;

(2) …;

(3) …;

(4) A doctor's complaint about repeated incidents in which Plaintiff allegedly addressed the doctors in an insulting and derogatory manner;

(5) the doctors' assertions that "Plaintiff has no respect from the staff in the department. He is a liar, manipulator and back stabber. Staff in the department are angry, disillusioned, disoriented and suffer low morale";

(6) …; and

(7) The concern "that Plaintiff is not very knowledgeable of basic X-Ray technique, and that Plaintiff really does not know what physicians are technically trying to accomplish in the department."

After the letter was signed by the doctor's acknowledging that it represented a fair statement of their grounds for requesting Plaintiff's termination, the letter was shared with Plaintiff and an investigation was conducted. After that investigation, in June of 1994, it was concluded that no further action should be taken on the doctors' complaints about Plaintiff.

Disharmony in the radiology department continued through that summer and fall. All relationships with Plaintiff clearly deteriorated. In January of 1995, the head of radiology decided to terminate Plaintiff's employment. The reasons for his decision, as detailed in his notes, were the following:

1. No relationship with radiologists.
2. Significant late evaluations.
3. Office problems worsening rather than improving.
4. Incredibly poor communications skills (verbal and written).
5. Enclave mentality - seems unable to interact with staff without someone becoming upset (consistent in my personal observations/interactions with offensive/inappropriate comments and use of offensive/inappropriate expletives).

Plaintiff's defamation claim is based on the 1994 letter, identifying the SCRG doctors' reasons for requesting that Plaintiff be terminated. Plaintiff has claimed that this letter constituted libel *per se*, because it accused Plaintiff of being a liar and impugned his ability to perform his job adequately.

The law of defamation consists of the twin torts of libel and slander, and the gist of a defamation action is the publication of written or oral statements that tend to injure a person's reputation and good name. *Slander* generally consists of the oral publication of defamatory matter. *Libel* in Iowa is the malicious publication, expressed either in printing or in writing, or by signs and pictures, tending to injure the reputation of another person or to expose [the person] to public hatred, contempt, or ridicule or to injure [the person] in the maintenance of [the person's] business.

As the Iowa Supreme Court recently explained, to establish a *prima facie* case of defamation, a plaintiff must show that the defendant:

(1) published a statement that was

(2) defamatory

(3) of and concerning the plaintiff.

In order to prevail on a defamation claim, a plaintiff must ordinarily prove that the statements were made with malice, were false, and caused damage. However, some statements, in a special category of defamation "*per se*," are actionable without proof of malice, falsity, or special harm. Words are defamatory *per se* if they are of such a nature, whether true or not, that the court can presume as a matter of law that their publication will have libelous effect. Among such statements are defamatory imputations affecting a person in his or her business, trade, profession, or office. Iowa courts have also repeatedly held that it is libel *per se* to publish statements accusing a person of being a liar, cheater, or thief.

The statements in question here, include statements that Plaintiff was not competent in his employment, and was a liar. The court holds that, as a matter of law, the statements in question constitute libel *per se*. This is not to say that the court takes any position on the truth or falsity of the statements--that will be for the jury to decide. A finding that the statements are libelous *per se* relieves the plaintiff of the obligation to prove that the statements were false. The truth of the libelous statements remains as an absolute defense to liability for those statements.

CASE EXAMPLE 2 – Communication: "ED Physician has Hepatitis C"

Nelson v. Glynn-Brunswick Hospital, 2002 WL 31109368 (decided Sept. 24, 2002).

Plaintiff, an employee of Sterling Miami, Inc. "Sterling", pursuant to a contract served as the medical director of the emergency department of Southeast Georgia Regional Medical Center. Prior to becoming the medical director, Plaintiff as a physician, had obtained patient treatment privileges at the hospital and had agreed to abide by its policies and procedures.

On March 18, 1997, during treatment of a patient, Plaintiff received a suture needle stick, and, following hospital protocols, his blood was tested for certain viruses. The lab results were positive for Hepatitis C virus (HCV) antibodies. The results of Plaintiff's hospital blood test were orally relayed from the lab technician to the lab director, who contacted the Defendant hospital administrator. Together, they discussed with the Director of Nursing the seriousness of the results. The hospital administrator then telephoned Plaintiff, who advised that he knew that the test results would come back positive, apparently because of a ten-year-old incident.

The next morning, the hospital administrator consulted the hospital's legal counsel, and they decided to assemble an ad hoc group of physicians to discuss the situation. Prior to the meeting of this group, steps were taken to ensure that Plaintiff's test records would not include his name, and his situation was discussed without release of his name to the ad hoc group. The group met on March 27, 1997, but no consensus recommendation was reached. Coincidentally, that same day, the National Institute of Health published a new draft consensus statement of health care experts on the management of the disease. The following day, the hospital administrator sent a letter to Sterling stating that Plaintiff had been "diagnosed with Hepatitis C" and that upon the recommendation of the Wellness Committee, the hospital was limiting Plaintiff's privileges to non-invasive care for the safety of the patients until the hospital's Executive Committee could meet.

Shortly thereafter, the Executive Committee held its regularly scheduled meeting, which Plaintiff attended. As a result of the meeting, on April 2, 1997, the hospital administrator notified Sterling that there would be no further restrictions on Plaintiff other than the practice of universal precautions. Plaintiff brought suit against the hospital alleging slander and libel in addition to 4 other charges.

Plaintiff asserts that questions of fact exist as to (1) whether the oral communication of his diagnosis to the hospital administrator and other hospital staff constitutes slander and (2) whether the hospital administrator's letter to Sterling containing the statement that Plaintiff was "diagnosed with Hepatitis C" was libelous. Slander includes oral defamation, which charges that a person has some contagious disorder, which may exclude that person from society. Libel, on the other hand, is an expression in writing of a false and malicious defamation, which tends to harm a person's reputation or would cause a person to be the subject of public hatred, contempt, or ridicule. A cause of action for libel or slander will fail if the statement is shown to be truthful.

The record shows that Plaintiff's blood test did indicate that the Hepatitis C antibodies were present in his blood. Thus, the fact that Plaintiff had been so diagnosed was true. Even if we assume that the statement that Plaintiff was diagnosed with Hepatitis C was false, based upon the fact that a single test is not sufficient to determine that one is infectious, and that such diagnosis constitutes a defamatory statement that one has a contagious disease which might exclude a person from society and subject that person to contempt, hatred, or ridicule, Plaintiff's claims have no merit, as the statements were not published, were privileged, and were made without malice. The hospital had a duty to the public and to its patients to safeguard them from infectious diseases within their

control. There is no question that Hepatitis C is an infectious disease. The hospital immediately took action to meet its duty to protect the public, until it satisfied itself that Plaintiff, in his medical condition, did not endanger others.

In order to recover for libel or slander, the statement must be published; communication to any other person constitutes publication. The oral communication of Plaintiff's blood test results from the lab technician to the lab director, and then to the hospital administrator and other members of the hospital staff including the Executive Committee, did not constitute publication. When the communication is intracorporate, or between members of unincorporated groups or associations, and is heard by one who, because of his/her duty or authority has reason to receive the information, there is no publication of the allegedly slanderous material, and without publication, there is no cause of action for slander.

Recovery for slander is also barred if the statement made was a privileged communication unless actual malice is proven. Communications are deemed privileged if they are statements made in good faith in the performance of a legal or moral private duty, or statements made with a good faith intent on the part of the speaker to protect his or her interest in a matter in which it is concerned. A defendant relying on privilege must show good faith, an interest to be upheld, a statement properly limited in scope, a proper occasion, and publication to proper persons.

Clearly, the hospital administrator and the medical center had an interest in protecting the safety of their patients and their own corporate interests in this case. The record clearly demonstrates that the hospital acted in good faith. The administrator testified that his actions were taken under the medical center's policy permitting the release of patient medical information on the basis of a true health care emergency or an unusual, rare circumstance where serving the common good outweighs privacy considerations. His beliefs were not unreasonable in light of the published authorities on HCV from the U.S. Department of Health & Human Services and the Center for Disease Control, which were available at that time. These publications, relied upon by hospital staff to assess the seriousness and infectiousness of the disease, stated that although the risk of HCV transmission in occupational settings was not well-defined, all antibody HCV positive persons should be considered potentially infectious and that current tests did not provide a reliable measure of the degree of infectiousness of the affected individual.

Further, the U.S. Department of Health & Human Services publication stated that about half of all persons who have HCV never recover and carry the virus for the rest of their lives. In order to assert the privilege of good faith, the hospital also has to show that the communication was limited to proper persons. The record indicates that communication of Plaintiff's test results was limited to persons directly concerned with the safety of the public and the interests of the hospital. The lab director provided the test results to the hospital director out of her concern for the safety of the patients and Plaintiff's health. Thereafter, the administrator, who is not a physician, consulted the Director of Nursing to confirm the seriousness of the test results and the hospital legal counsel to determine what to do. He also spoke with his Chief Officer of Operations, because that officer took the administrator's place at the ad hoc committee meeting during his absence.

The administrator also limited disclosure of Plaintiff's diagnosis by instructing the staff to take steps to keep the information confidential, replacing Plaintiff's name on his records with initials or with "John Doe." Plaintiff's name was not even released to the members of the ad hoc committee. Plaintiff cannot complain of the communication to the Executive Committee, since he made sure that the issue would be on the meeting agenda and was in attendance at that meeting. Under these circumstances, we find that the oral statements sharing Plaintiff's test results clearly fall within a good faith privilege.

For the same reasons, the letter written from the hospital to Sterling was protected by a good faith privilege, and there is no issue of fact as to Plaintiff's libel claim. It was reasonable for the administrator to contact Sterling, who was Plaintiff's direct employer.

Lastly, although a good faith privilege may be overcome by evidence of actual malice, Plaintiff presents no evidence that the discussion of his status among hospital staff or the letter written to Sterling was done maliciously.

CASE EXAMPLE 3 – Defamation of MD as a "Public Figure"

Franzon v. Massena Memorial Hospital, et. al., 89 F. Supp. 2d 270 (decided March 21, 2000).

Plaintiff claims that Defendants retaliated against him for speaking in favor of offering nurse-midwifery services at Massena Memorial Hospital ("MMH"); and speaking out about the high rate of Caesarian section deliveries at

MMH. Plaintiff alleges that Defendants have engaged in a campaign of overt and malicious acts to silence him consisting of making defamatory statements about his competence as a physician, is addition to other actions not pertinent to this topic.

This claim arises out of a telephone call. Defendant placed the call to a patient. During the course of that telephone conversation, Defendant stated that Plaintiff: (1) "jeopardizes patient['s] welfare;" (2) "makes mistakes;" (3) "almost lets [patients] bleed to death;" and (4) neglects patients in need of immediate medical attention.

Under New York law, there are, generally speaking, four elements necessary to establish a prima facie case of slander:

(1) an oral defamatory statement of fact,
(2) regarding the plaintiff,
(3) published to a third party by the defendant, and
(4) injury to the plaintiff.

Because the applicable standard and ensuing discussion are dependent upon Plaintiff's status as a private or public figure, the Court will first address that issue. Defendant argues that Plaintiff is a public figure and, therefore, must ultimately prove that Defendant acted with actual malice in making the alleged defamatory statements.

In ascertaining whether a defamation plaintiff is a public figure, the Second Circuit has created a four-part test:

> A defendant must show the plaintiff has: (1) successfully invited public attention to his views in an effort to influence others prior to the incident that is the subject of litigation; (2) voluntarily injected himself into a public controversy related to the subject of the litigation; (3) assumed a position of prominence in the public controversy; and (4) maintained regular and continuing access to the media.

Applying these factors, for the following reasons, the Court finds that Plaintiff is a limited public figure for purposes of the instances alleged in the Complaint and, thus, has the burden of demonstrating both that the alleged statements are false and that Defendant acted with knowledge of falsity or a reckless disregard for the truth.

First, the evidence demonstrates that Plaintiff successfully invited public attention to his views in an effort to influence others prior to the incident that is the subject of litigation. It appears from the evidence that the issue of granting privileges to nurse midwives at MMH was a hotly contested issue in the Massena area and one in which Plaintiff took an active role.

Plaintiff attempted to garner public support for the granting of hospital privileges to a nurse midwife on his staff. In addition to the allegations contained in the Complaint, the significant media coverage surrounding the issue further evidences that Plaintiff invited public attention to his views in an attempt to influence others.

Second, Plaintiff voluntarily injected himself into the controversy surrounding the issue of granting privileges to nurse midwives at MMH and the non-renewal of his hospital privileges. This also is evidenced by the extensive media coverage surrounding the nurse-midwifery issue and the instant litigation.

Third, the evidence further demonstrates that Plaintiff has assumed a level of prominence in the public controversy. It is clear that Plaintiff was one of the leading forces behind the nurse-midwife movement in Massena and the community recognized him as such. Plaintiff's prominence is evidenced by, for example, letters to the editor and other newspaper articles discussing the nurse-midwifery issue and recognizing Plaintiff as a central figure in the debate.

Accordingly, the Court finds that Plaintiff is a limited public figure and, therefore, in order to sustain his defamation cause of action against Defendant, must demonstrate both that the alleged defamatory statement are false and that Defendant spoke with actual malice.

Defendant argues that because there was an incident where Plaintiff cared for a patient who had a significant loss of blood and remained very anemic despite receiving two units of blood, his statements are true. Defendant also maintains that this case was reviewed by MMH's quality assurance program, which found that the incident was avoidable. This evidence satisfies Defendant's burden of demonstrating belief in his statements. While truth, or substantial truth, unquestionably is an absolute defense to a defamation claim in a suit such as this one involving a public figure, the plaintiff bears the burden of proving falsity.

Plaintiff, made no effort to demonstrate whether the alleged defamatory statements are, indeed, false. In fact, Plaintiff never discussed the truthfulness or falsity of Choi's statements. This claim of defamation failed.

CASE EXAMPLE 4 – Damages

Chalal v. Northwest Medical Center, Inc., 147 F. Supp. 2d 1160 (decided March 31, 2000).

Plaintiff alleges that he was defamed by statements made by hospital representatives to patients after his privileges were not advanced to active status. To establish a defamation claim under Alabama law, a plaintiff must prove:

(1) a false and defamatory statement concerning the plaintiff;
(2) an unprivileged communication of that statement to a third party;
(3) fault amounting at least to negligence on part of the defendant; and
(4) either actionability of statement irrespective of special harm or the existence of special harm caused by publication of the statement.

The Alabama Supreme Court held that statements which do not impute the commission of a crime involving infamy or moral turpitude require proof of actual damages in order to support a claim for defamation, explaining as follows:

> Generally, in slander there must be an oral communication of a defamatory matter to a third person. . . . There are two types of slander, *slander per se* and *slander per quod*.
>
> Slander per se is actionable if it imputes to the plaintiff an indictable offense involving infamy or moral turpitude. . . . Damage is implied by law when spoken words are found to be slander per se.
>
> Slander per quod is a communication to a third person of a defamatory statement subjecting the plaintiff to disgrace, ridicule, odium, or contempt although not imputing the commission of a crime involving infamy or moral turpitude.

In the present case, the alleged statements do not accuse Plaintiff of committing an indictable criminal offense involving infamy or moral turpitude and therefore, at worst, constitute slander per quod. Therefore, Plaintiff must present evidence of actual damages.

Plaintiff has produced no evidence that he lost a single patient visit or was otherwise damaged as a result of the alleged statements. To the contrary, Plaintiff admitted during his deposition that he knows of no patients who stopped seeing him as a result of any alleged remarks by the Hospital. Without evidence of damages, Plaintiff's defamation claim fails.

TSG Commentary

Defamatory statements must be factual, not opinions. Opinions are not considered actionable. Therefore, a statement like "Dr. Smith is really a jerk" is not slander, it is simply a statement of opinion. However, this statement "Dr. Smith takes sexual advantage of his patients," is a statement of fact, and if false would be actionable under the laws of defamation.

In order to establish a prima facie case for defamation, the following elements must be proven:

1) defamatory language on the part of the defendant;
2) the defamatory language which must be "of or concerning" the plaintiff. That is, it must identify the plaintiff to a reasonable reader or listener or viewer;
3) publication of the defamatory remark by the defendant to a third person;
4) damage to the reputation of the plaintiff;
5) fault on the defendant's part.

Defamatory language is language that tends to adversely effect one's reputation. This may result from impeaching the individual's honesty, integrity, virtue, or sanity.

The law imposes a fault requirement in certain cases. The degree of fault to be established may depend on the type of plaintiff i.e. whether it is a public official or public figure as compared with a private person plaintiff.

With public figures, malice is required. Malice is knowledge that the statement is false or reckless disregard as to its' truth or falsity. It must be shown that the defendant was subjectively aware that the statement he published was false or that he was subjectively reckless in making this statement. It is not enough that the defendant be shown to have acted with spite, hatred, ill will, or intent to injure the plaintiff.

A person may be deemed a "public figure" on one of two grounds. First, where he has achieved such pervasive fame or notoriety that he becomes a public figure for all purposes (e.g. celebrity sports figure). More commonly a person becomes a public figure when he injects himself or is drawn into a particular controversy (e.g. prominent

community activist) and thereby becomes a "public figure" for that limited range of issues.

Awareness of the tort of defamation is important in today's highly litigious environment. Emergency and other health practitioners must be extremely careful when speaking out, or creating written documents that may contain potentially defamatory content. Defamation often occurs in situations where an individual has absolutely no knowledge that such a statement or written communication may be illegal. It is important for health practitioners to understand the basics of the law of slander and libel. There are enough legal pitfalls out there. Carefully monitor your communications. It is often very helpful to think first, then communicate! ♦

Special Issue

Critical Care Coding

Thanks to Rebecca Parker, M.D., FACEP for this contribution on coding and billing in emergency medicine. "Condensed from "Introduction Coding & Billing" ©2002, Team Parker LLC". Dr. Parker specializes in coding and billing and fraud and abuse issues in emergency medicine. You can contact Dr. Parker at www.teamparker.net, rbparkermd@ameritech.net or by phone 847-295-3491.

Critical Care Reimbursement and Compliance

By Rebecca B. Parker, MD, FACEP
TEAM PARKER, LLC
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"Critical Care — it's an E&M Thing."

As reimbursement for Medicare physician services decreases, you want to ensure proper reimbursement for the services you provide. At the same time you must stay compliant with the ever-changing Medicare rules, thus avoiding fraud and abuse. The following article describes how to meet both these goals and capture a commonly missed code series—Critical Care.

Critical Care is a service commonly delivered in the emergency department; however, the coders often are unable to capture this Evaluation and Management (E&M) service because the physician has to declare the patient is Critical Care. Financially, the initial Critical Care service, the first 30-74 minutes, has a higher relative value than any other ED E&M code and consequently has higher reimbursement. As the only time based code in Emergency Medicine, Critical Care also allows a repeat charge every 30 minutes.

For example, you assess, stabilize, and administer thrombolytics to an acute MI patient. Care is on and off for a total of 2 hours before they are transferred for cardiac cath. You document and reach all the criteria for a Level 5 E&M service (99285). For 2002, the 75th percentile AMA charge for 99285 is $274. If you had identified this patient as a critical care patient, and this patient does qualify as critical care, 120 minutes of critical care service qualifies you to use the following Critical Care codes:

(1) 99291. This code is for the first 30-74 minutes. The 2002 75th percentile AMA charge is $356.

(2) 99292 X 2. The 99292 code is for every 30 minutes after 74 minutes. The 2002 75th percentile AMA charge is $183.

In this scenario the total charge for Level 5 would be $274, but the total charge assigning critical care would be $722. By not knowing the rules, *you reduce your reimbursement by more than half*, because the patient receives a Level 5 service code rather than the applicable critical care codes. Missing critical care charges, revenue you deserve for work performed, is obvious monetary loss to both you and your group.

"I'm not sure if my patient is Critical Care."

In 2000, the AMA's CPT and CMS (previously HCFA) agreed that the general definition of a critical care patient is one who is unstable or potentially unstable. For CMS, which has the clearest definition of the two organizations, a critical care patient is a patient where "There is a high probability of sudden, clinically significant, or life threatening deterioration in the patient's condition which requires the highest level of physician preparedness to intervene urgently. The failure to initiate these interventions on an urgent basis would likely result in sudden, clinically significant or life threatening deterioration in the patient's condition." You must provide a minimum of 30 minutes of Critical Care Services for the patient to qualify.

"Okay, my patient meets the definition for Critical Care and I've been attending them for 30 minutes. Now what?"

You must document that the patient is a critical care patient and write down the total minutes you provided

critical care services. To qualify for Critical Care, you need a minimum of 30 minutes. Your diagnosis must support your Critical Care claim, and you must document your frequent reassessments or any other supporting evidence that qualifies your patient as Critical Care. These are the minimum requirements. There are no elements or organ systems for this code. Please realize that your coders will not code the Critical Care service unless you, the physician, specifically states that the patient is a critical care patient.

"I'm not sure what time counts towards critical care."

Here's what counts:

- Time spent directly with the patient
- Reviewing results
- Discussing the case with other medical staff
- Conversations for medical decision making or history gathering with family or surrogate medical decision makers, as long as it bears directly on patient management.

When dealing with surrogate decision makers, the chart should clearly specify why the patient cannot participate. The time does not have to be continuous. Time spent on separately billable procedures, (e.g.; intubations, CPR, CVP, etc), does not count—you are charging separately for these services. Of note there are certain physician procedures, usually billed separately, that are bundled into critical care charges: chest X-ray interpretation, pulse ox interpretation, gastric intubation, transcutaneous pacing, blood gases, and IV starts or blood draws. Any time spent on these later procedures counts toward critical care time. Also realize, if a patient qualifies as a Critical Care and boards in the ED, every extra 30 minutes you spend providing critical care services is an additional, and appropriate, critical care charge.

In Summary

The next time you have a patient that you pay close attention to for medical reasons, and this patient would deteriorate without your intervention, realize that they most likely meet the definition of a Critical Care patient. Document that they are a critical care patient, support your reasons in the chart, and document how many total minutes you provided. If time was spent with the family, clearly show how the family's participation directly relates to patient management, and why the patient could not participate. Finally, do not include separately billable procedures in the total time. Here's a sample statement for your chart:

> Mr. Smith received 120 minutes of critical care services for status asthmaticus and respiratory failure. The family provided history and decided on intubation as Mr. Smith was unconscious. Separately billable procedures were not included in the critical care time.

That's it. The coders have what they need to code for the Critical Care services you provided. Be sure to document your reevaluations and total your time—your coders will do the rest. ♦

EMTALA Update

All of the EMTALA legislative and administrative documents are available through www.thesullivangroup.com home page.

1. Delay in Publication of New Regulations. As you know from the TSG Summer Quarterly Report, CMS has published proposed new EMTALA regulations. The new regulations contain several significant changes to EMTALA. For a review, take a look at the TSG Summer Quarterly Report, or download the newsletter from the TSG website.

We are currently awaiting the final regulations after public comment. The final regulations were supposed to be published on October 1, 2002. They were not published as scheduled.

TSG contacted CMS and asked about the time frame for publication. We were told that CMS is hoping to publish by years end, 2002. Also, be aware that in general, regulations do not take effect until 60 days after publication. Therefore, the new regulations will not take effect until sometime in late February or March of 2003. We felt it was important to communicate these time frames to our readers. If there are further delays we will keep you up to date.

2. CMS Addresses On-Call Physician Coverage. Steven Pelovitz is the director of the Center for Medicaid and State Operations' Survey and Certification Group. Mr. Pelovitz periodically publishes letters to his associate regional administrators regarding controversial EMTALA issues. He has recently published two letters related to on-call physicians. If you would like to read the letters go the www.thesullivangroup.com home page and click on EMTALA on the upper navigation bar. Both letters are accessible on the page that opens.

Mr. Pelovitz highlights the current hospital requirements regarding bylaws addressing on-call physician responsibilities and the hospital having a policy and procedure available when a particular specialty is not available on the on-call list.

Mr. Pelovitz's comments then indicate that it is acceptable for a physician to be on-call at more than one hospital but points out that each hospital has an independent EMTALA obligation. That is, the hospital must have a plan in place for when an on-call physician is unavailable because he or she is busy providing service at another hospital.

In his second letter, Mr. Pelovitz states that the hospital does not have to have on-call specialty coverage for each specialty 24 hours per day, 365 days per year. The hospital maintains discretion as to how the on-call schedule is set up. There are no ratios or formulas for coverage. If a day is not covered by a specialist on the on-call schedule, that service is simply not within the capability of the hospital on that particular day. The hospital must have a policy to provide that specialty service in some other fashion (eg, transfer).

These and other issues will be addressed in the forthcoming regulations. Take a moment and read Mr. Pelovitz's letters.
http://cms.hhs.gov/medicaid/ltcsp/sc0235.pdf
http://cms.hhs.gov/medicaid/ltcsp/sc0234.pdf

EMTALA Case Review

Bauman v. Tenet Healthsystem Hospitals, Inc.
E.D.La.,2002. Jan. 11, 2002.

Louisiana Hospital survives EMTALA challenge

On January 11, 2002 the eastern district of Louisiana held, that a Louisiana hospital successful satisfied the conditions of EMTALA, when a patient received a non-urgent condition diagnosis, refused supplemental treatment, and was transferred to another facility. Plaintiff, Bauman alleged that Meadowcrest Hospital "failed to perform a medical screening, stabilize the complainant, or secure his transfer to another facility, despite the fact that he was suffering an emergency medical condition."

On April 17, 1999, Mr. Bauman presented into the Emergency Department ("ED") of Meadowcrest Hospital with pain in his jaw. He was triaged by a nurse and seen by an emergency physician who performed a clinical exam and ordered x-rays of the patient's jaw, cervical spine and two views of his chest. Meadowcrest Hospital's assessment of patient's triage status indicated that his condition was "non-urgent." Meadowcrest diagnosed patient as having an open mandible fracture (a broken jaw). The emergency physician administered a medical screening examination to the patient that Meadowcrest Hospital would have offered any other patient in a similar condition with similar symptoms.

Within the staff and facilities available at Meadowcrest Hospital, further medical examination and treatment were offered to plaintiff, in addition to an explanation of the risks and benefits of that treatment. The patient refused further treatment and examination and requested transfer to another facility. Meadowcrest then arranged for the transfer of the patient to another medical facility by contacting the physician at Charity Hospital to accept the patient, as well as completing the necessary transfer documents. The patient signed the "Patient Consent for Transfer," and has indicated that he acknowledged receiving a medical screening at Meadowcrest Hospital; that further medical treatment was required; that the potential benefits of transfer outweighed the risks; and that he consented to transfer, thereby releasing the physicians and hospital from any and all liability. The transfer

procedure and checklist were completed on April 17, 1999, and signed by the patient, the emergency physician, and a witness.

The patient's condition was stabilized and an ambulance was arranged for his transfer to Charity Hospital, upon which he refused. Rather than using the ambulance provided, Mr. Bauman left Meadowcrest Hospital via cab, and was taken to his office to get his insurance card. Contrary to Meadowcrest Hospital's recommendation and transfer accommodations to Charity Hospital, Mr. Bauman presented himself to West Jefferson Hospital at approximately 11:35 a.m.

The first subsection of EMTALA that Plaintiff alleges Meadowcrest Hospital has come into violation of is 42 U.S.C. § 1395dd. This portion of the Act is comprised of two provisions: the medical screening provision and the treatment or transfer provision.

Medical Screening

Initially, the hospital must provide to an individual that comes to its emergency department an appropriate medical screening examination to determine whether or not an emergency medical condition exists. An EMTALA 'appropriate medical screening examination' is "a screening examination that the hospital would have offered to any other patient in a similar condition with similar symptoms. If the hospital thereafter determines that an emergency medical condition exists, the Act then requires the hospital to provide *either:*

(A) within the staff and facilities available at the hospital, for such further medical examination and such treatment as may be required to stabilize the medical condition, or

(B) for transfer of the individual to another medical facility in accordance with the transfer provisions of this act.

Plaintiff contended that Defendant, Meadowcrest Hospital, did not meet the requirements of EMTALA in performing an appropriate medical screening. The Louisiana Court found that this argument lacks merit because, Plaintiff admitted that he "does not contend that insufficient tests or diagnostic procedures were done." Mr. Bauman, likewise, received an appropriate medical screening examination when he presented himself to Meadowcrest Hospital on April 17, 1999. The treating ED physician, testified to the care rendered to Mr. Bauman, in that he was examined, given a diagnosis of a "non-urgent" condition, sent for x-rays of his mandible, his cervical spine, and a 2-view chest x-ray. The Doctor was asked to testify as to whether or not Mr. Bauman received a medical screening that Meadowcrest Hospital would have offered to any other patient in a similar condition with similar symptoms, the doctor responded affirmatively.

Stabilization

Plaintiff contends that Meadowcrest Hospital, in addition, did not satisfy the EMTALA stabilization and transfer requirements. The Court finds that based on the supporting evidence presented, this argument also lacked merit. Dr. Loe offered Mr. Bauman further medical assistance, and he did not consent to any supplemental treatment. Upon Mr. Bauman's refusal, the second provision of the EMTALA was satisfied.

An emergency medical condition is 'stabilized' if "no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility." Once the individual's medical condition is stabilized, the hospital's responsibility under the EMTALA ends.

EMTALA does not require "treatment *or* stabilization." The law requires, upon diagnosis of an emergency condition, "treatment/stabilization *or* transfer," either of which requirement is deemed to be satisfied when the patient refuses that which is offered. Plaintiff did refuse such further treatment, and, by law, Meadowcrest Hospital satisfied this provision of EMTALA.

Transfer Provisions

Meadowcrest Hospital satisfied this second provision of EMTALA in accommodating Mr. Bauman's transfer in that:

1) Dr. Loe signed the certification that based upon the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweighed the increased risks to the individual; § 1395dd(c)(1)(A)(ii).

2) Meadowcrest Hospital provided the medical treatment within its capacity to minimize the risks to Mr. Bauman; § 1395dd(c)(2)(A).

3) Charity Hospital, the receiving facility, had adequate space for the treatment and agreed to accept the transfer; § 1395dd(c)(2)(B).

4) Meadowcrest Hospital sent with Mr. Bauman the medical records related to his condition; and § 1395dd(c)(2)(C).

5) Meadowcrest Hospital arranged for appropriate transportation. § 1395dd(c)(2)(D).

Dr. Loe completed and signed a Patient's Transfer Checklist and Physician Certification for a Patient Transfer. Those documents set forth: Mr. Bauman's diagnosis, that Dr. Waltrip at Charity Hospital agreed to accept the transfer, that Mr. Bauman's condition was stabilized, the risks and benefits reasonably associated with the transfer, and that Mr. Bauman consented to the transfer.

Meadowcrest Hospital "is deemed to meet the requirement of [the transfer component of EMTALA] if the hospital offers to transfer the individual to another medical facility in accordance with subsection (c) of this section and informs the individual ... of the risks and benefits to the individual of such transfer, but the individual ... refuses to consent to the transfer."42 U.S.C. § 1395dd(b)(3). By Mr. Bauman's own admission, he was offered transportation to Charity Hospital. The risks and benefits of the transfer were set forth as well in the documents on which he identified his signature; but he refused the transportation nonetheless.

As related to the stabilization component of the second provision of the EMTALA, "a hospital is deemed to meet the requirement of the transfer component of EMTALA if the hospital offers to transfer the individual to another medical facility and informs the individual ... of the risks and benefits to the individual of such transfer, but the individual ... refuses to consent to the transfer." In terms of the consent to treatment and the consent to transfer, "the hospital shall take all reasonable steps to secure the individual's written informed consent to refuse such examination and treatment / such transfer."

An "appropriate transfer" to a medical facility is a transfer in which "the transferring hospital provides the medical treatment within its capacity which minimizes the risks to the individual's health," and in addition "sends to the receiving facility all medical records related to the emergency condition for which the individual has presented, available at the time of the transfer."

Delay In Treatment

The subsection provides: "[a] participating hospital may not delay provision of an appropriate medical screening examination OR stabilization treatment in order to inquire about the individual's method of payment or insurance status. Plaintiff contends that not only did he have to wait for extensive periods of time in an examination room, but when he requested treatment from Dr. Loe, she refused based on his lack of insurance. The Court finds that this argument lacks merit as well.

Mr. Bauman presented himself to West Jefferson Hospital and was examined by ED physician, Dr. Chugden, and oral surgeon, Dr. Indovina. At approximately 3:15 p.m., Dr. Indovina wired Mr. Bauman's fracture, sutured his laceration, and applied bandages in the ED. While Mr. Bauman contends that he went "9 hours" without treatment at Meadowcrest Hospital, it should be noted that he cites in his opposition that he was checked into West Jefferson at approximately 11:35 a.m. According to his medical records, because he checked out of Meadowcrest Hospital at approximately 9:45 a.m., he was only at Meadowcrest Hospital for approximately 4 hours. It is, therefore, impossible that Mr. Bauman was neglected for 9 hours at Meadowcrest Hospital. Approximately 2 hours lapsed before he presented himself to West Jefferson Hospital at 11:35 a.m., where he was treated approximately another 4 hours later for his injuries.

As to whether or not treatment was delayed to Mr. Bauman because of Meadowcrest [Hospital]'s inquiries into his insurance coverage, even the most scant review of Mr. Bauman's medical record shows that there is no delay in his care. In summary, he was first seen at Meadowcrest Hospital at approximately 5:40 a.m. He signed the transfer papers at 9:45 a.m. In those few hours, Mr. Bauman was triaged by a nurse; was seen by Dr. Silady, the ED physician on duty before Dr. Loe; was sent to radiology where an x-ray of his chest, and x-ray of his spine, and an x-ray of his jaw were taken; returned to be seen by Dr. Loe, who was then on duty, and diagnosed his condition; was offered further treatment; and was fitted with a C-collar that he was wearing when he was presented to West Jefferson Hospital. The medical record contains entries throughout this time period. ♦

Landmark Case Review

TSG will present landmark cases in this section of the newsletter. In general, a landmark case is one that significantly changes existing law. We will expand that definition to include a wider range of cases that have, or could have had, a significant impact on the practice of emergency medicine.

Roberts v. Galen of Virginia, Inc.
525 US 249
Decided: January 13, 1999

This is the first EMTALA case that made its way to the Supreme Court. The Supreme Court addressed a very

narrow issue in dispute between the several Circuit Courts around the country. The issue concerned whether a plaintiff needs to show *first*, a failure to properly screen and *second*, that it was done with improper motive. The Supreme Court decided that there was nothing in § 1395dd(b) requiring plaintiffs to prove an improper motive in failing to stabilize a patient before transferring the patient.

The Facts

Plaintiff Wanda Johnson, who was uninsured, sustained severe injuries in a traffic accident and was admitted to Humana Hospital-University of Louisville (doing business as Galen of Virginia) in May 1992. After about a six-week stay at Humana, the surgical resident treating Johnson asked a social worker to find a long-term care facility for Johnson. Johnson was transferred to Crestview Health Care Facility in Indiana on July 24, 1992.

The day after her transfer, Johnson's condition deteriorated. She was taken to Midwest Medical Center, also in Indiana, where she remained for many months and incurred substantial medical expenses. The State of Indiana refused Johnson's application for Medicaid assistance because she did not meet Indiana's residency requirements.

The EMTALA Lawsuit

Plaintiff Jane Roberts, Johnson's guardian, sued Humana for breach of its duty to Johnson under the Emergency Medical Treatment and Active Labor Act when it transferred Johnson to Crestview while her medical condition was unstable.

What the Courts Did

The Federal District Court granted summary judgment to Humana on the EMTALA claim because it found that the plaintiff had failed to prove that Humana's motive for transferring Johnson had been improper. Plaintiff appealed.

The Sixth Circuit Court of Appeals affirmed, holding that in order to recover in a suit alleging a violation of the EMTALA stabilizing requirement, a plaintiff must prove that the hospital acted with an improper motive (e.g., financial or racial discrimination). The Court of Appeals read § 1395 dd(a)'s "appropriate medical screening" duty as requiring a plaintiff to show an improper reason why he or she received "less than standard attention upon arrival at the emergency room". Plaintiff again appealed.

In a per curiam opinion[1] the U.S. Supreme Court reversed the Sixth Circuit and held that there was nothing in § 1395dd(b) requiring plaintiffs to prove an improper motive in failing to stabilize a patient before transferring the patient.

The Supreme Court only looked at the EMTALA issue. Because the EMTALA claims were not sufficiently developed in the lower Court's decision for the Supreme Court to review them, the Supreme Court reversed the Sixth Circuit's holding that the Federal District Court properly granted summary judgment for defendant, and remanded the case for further proceedings.

Importance of the Supreme Court's Decision

"But there is no question that the text of § 1395dd(b) does not require an "appropriate" stabilization, nor can it reasonably be read to require an improper motive. This fact is conceded by respondent, which notes in its brief that "the 'motive' test adopted by the court below . . . lacks support in any of the traditional sources of statutory construction." Brief for Respondent 17. Although the concession of a point on appeal by respondent is by no means dispositive of a legal issue, we take it as further indication of the correctness of our decision today, and hold that § 1395dd(b) contains no express or implied "improper motive" requirement.

Results of the Remand to the Lower Court

Further proceedings in the Western District of Kentucky resulted in Defendants motion for summary judgment being denied because the court found that there was an issue as to whether or not Johnson was stabilized prior to her transfer from the hospital. Specifically the court said, "the definition of "transfer" … makes it clear that Congress intended to hold hospitals directly accountable for the actions of physicians and other medical personnel.[2] The definition imposes liability upon the hospital for the actions of persons "affiliated or associated, directly or indirectly" with the hospital. The surgical resident that made the decision to transfer Johnson in this case falls within that definition, and Humana could be held directly accountable under EMTALA for his actions."

Commentary

When the Supreme Court identifies a difference of opinion between the Circuit Courts on a particular issue, that issue is then considered ripe for Supreme Court review.[3] On review, the Supreme Court determined that Congress had not intended a two-pronged analysis, and that the "improper motive" prong was not the correct interpretation of EMTALA. Therefore, the Court sent the

case back to the Sixth Circuit to reconsider the matter without the "improper motive" test.

The Court's opinion did not shed any light on the obvious issue of the determination of stabilization following six weeks of hospitalization. It is hard to fathom a determination of failure to stabilize after a hospital stay of six weeks. ♦

For a reading of the Supreme Court" opinion, see the website:
http://supct.law.cornell.edu/supct/html/97-53.ZPC.html

Endnotes

[1]Per curiam is a phrase used to identify an opinion of the whole court from an opinion written by any one judge. See Black's Law Dictionary
[2] The Sec. of Health and Human Services supports the notion that hospitals are directly rather than vicariously liable for the actions of physicians and specifically said that, The statute imposes duties on a hospital, many of which can only be effectively carried out by physicians in some way affiliated with the hospital. Neither the statute nor the regulations attempt to define the means by which the hospital meets its statutory obligations to provide emergency screening examination, treatment or transfer . 59 Fed. Reg. 32,086, 32,115 (1994).
[3]The Supreme Court will only grant certiorari to cases that are ripe for judgment. A case is ripe for judgment if the legal issues are clear enough and well enough evolved and presented so that a clear decision can come out of the case. See Black's Law Dictionary 6th edition.

TSG Quarterly Report

At the crossroads of law and medicine

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