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INSIDE

RELIAS MEDIA

Many Future ED Malpractice Claims Will Need to Survive Gross Negligence Standard

Enacted protections offer emergency department (ED) providers some immunity from liability, except for gross negligence and willful and wanton conduct.[1] This leaves plaintiffs' attorneys with just one option for pursuing a medical negligence case.

"There will inevitably be an increase in allegations that actions or inactions previously considered to be ordinary negligence instead constitute gross negligence," says **Katharine C. Koob**, Esq., an associate at Post & Schell in Philadelphia. Koob says examples of conduct that could rise to the level of gross negligence in the ED include:

- failing to respond in a timely manner to a patient who is coding;
- administering an incorrect medication to a high-risk patient;
- failing to adhere to policies and procedures in place to prevent the spread of COVID-19 (e.g., permitting untested potential carriers into the ED despite visitor restrictions). "Plaintiffs' attorneys will undoubtedly begin to set forth claims for gross negligence to refute and avoid any liability protections put in place," Koob says.

Some claims are going to assert it was gross negligence for a hospital to be understaffed at a time when a surge of patients is anticipated, Koob predicts. Defense counsel can counter this allegation with proof that hospitals made every effort to appropriately staff the ED.

"Plaintiffs may attempt to argue that the hospital's actions were reckless and in wanton disregard for the well-being of their anticipated patient population in order to allow their clients' cases to proceed," Koob explains.

The definition of gross negligence varies from state to state. "It can range from a slight lack of diligence to conscious disregard for the well-being of others," says **Amy Evans**, JD, executive vice president of the liability division at Intercare Insurance.

Allegations of gross negligence, intentional conduct, assault, and battery generally are excluded from professional

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liability insurance coverage, Evans notes.

Plaintiffs occasionally plead these allegations because it allows for recovery of punitive damages, treble damages, and/or attorneys' fees.

"Talented plaintiff attorneys plead general medical negligence in addition to gross negligence and occasionally assault and battery, depending on the facts," Evans reports. Pleading gross negligence, she adds, "can also allow certain egregious and potentially prejudicial information into evidence that may otherwise be excluded."

To defend against gross negligence allegations, ED providers and hospitals will need to show that they were as prepared as possible under the circumstances.

Also, providers must show they followed evolving recommendations of federal and local health authorities.

If they can do that, says Evans, "gross negligence claims are going to be very difficult to sustain, let alone prove."

When a plaintiff attorney pleads gross negligence or intentional conduct, a judge decides whether the claim can proceed through final judgment.

"The plaintiff bears the burden of proof with regard to the allegations they assert," Evans explains.

The defense has two opportunities to challenge whether the plaintiff has met their burden, says Evans:

• **Before trial**: The defense can file dispositive motions, such as motions to dismiss or for summary judgment.

• **During trial**: The defense can bring motions for directed verdict, arguing to the court there is insufficient evidence to support the plaintiff's allegations.

"Most courts take allegations of intentional conduct against healthcare providers very seriously," Evans says. Courts consider sworn statements and testimony from fact witnesses and independent experts, medical records, and licensing board findings, among other evidence.

Evans says cases alleging gross negligence are likely to survive when another healthcare provider involved in the care supports the allegations the plaintiff asserts. Another scenario that could lead to survival is when there are allegations of inappropriate behavior. "It is difficult to obtain dismissal of 'he said/she said' types of allegations," Evans says. "They are generally seen as credibility issues for a jury to decide."

Regardless of whether a gross negligence claim survives, ED providers still endure the lengthy, costly litigation process.

"The ability of a claim to proceed will likely be visited, and revisited, at several points throughout the life of the case," Koob says.

Claims almost certainly need to proceed through the pleadings stage as well as the lengthy discovery process. All that must play out before a judge will consider dismissing the action based on liability protections created by legislation or executive order. "The judge will undoubtedly want to ensure that all of the relevant information has been gathered before denying the right of a plaintiff to assert a cause of action," Koob explains.

Some cases will end up dismissed before trial. However, it is likely many judges will determine a jury needs to decide whether the actions at issue rose to the level of "gross negligence."

"In that scenario, the case will need to be tried to verdict before a healthcare provider benefits from any potential liability protections," Koob observes. Actions that arguably represent ordinary negligence (e.g., poor clinical judgment or mistake) may

be designated as gross negligence. "Cases in which the care rendered falls in a 'gray area' will likely result in a determination by a judge that the care could be found to be grossly negligent," Koob says. This permits the case to proceed through the legal system and be heard by a jury. Liability protections might ultimately shield the ED provider from a verdict or judgment. "But it may be highly costly and time-consuming to arrive at that final determination," Koob adds. ■

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Long-Standing Gross Negligence Standards for ED Malpractice

Some states enacted stringent standards for asserting medical malpractice claims against emergency department (ED) providers long before the COVID-19 pandemic.

In Texas, a "willful and wanton negligence" requirement has applied since 2003 to healthcare liability claims that arise out of the provision of emergency medical care.[1]

"This is an exceptionally difficult standard to meet," says **David A. Hyman**, MD, JD, professor of health law and policy at Georgetown University.

Plaintiff attorneys in Texas probably will decline to take most cases involving ED treatment going forward, according to Hyman, "which, in turn, should result in a reduction of malpractice premiums for ED physicians."

The Texas statute permits a plaintiff to recover for mistreatment when the provider "departed from accepted standards of medical care" and the claimant establishes by a preponderance of the evidence that provider committed "willful and wanton negligence."

"The 'willful and wanton' standard has been taken to mean gross negligence," says **Charles Silver**, JD, a professor of law at the University of Texas at Austin. To establish gross negligence, Silver says a plaintiff must prove the provider's act or omission involved an extreme degree of risk. Additionally, the plaintiff must prove the provider knew of the risk involved, and proceeded with conscious indifference to it.

"The first element is objective. The second is subjective, meaning that it requires evidence of a provider's actual knowledge," Silver explains.

Plaintiff attorneys occasionally argue in medical malpractice cases that gross negligence occurred. "It is difficult to find examples of cases in which they succeed," Silver says. Here are three examples of unsuccessful attempts:

• In a 2016 case, the Texas Court of Appeals ordered that summary judgment be granted in favor of the defendants, who failed to diagnose rhabdomyolysis.[2]

This ultimately caused the patient to develop compartment syndrome and suffer an amputation. "The court found no evidence that the physicians departed from the standard of case so greatly as to create a severe risk of harm, and no evidence that they knew of the risk to the patient and ignored it," Silver reports.

• A patient died of a heart attack a few hours after discharge from the ED; the family sued.

The court of appeals sustained a jury verdict in favor of the nurses on staff, even though there was no disagreement that the patient was misdiagnosed.[3] After reviewing the evidence, the court agreed the nurses' mistake led to the patient's death. "But the court found a reasonable basis in the evidence for the jury's conclusion that the nurses neither disregarded what they knew to be pain of a cardiac origin, nor allowed a patient to be discharged whom they knew to be in an unstable emergent condition," Silver notes. The evidence showed only that the nurses failed to exercise reasonable care.

• The parents of a baby whose shoulder was dislocated during birth sued the obstetrician and the hospital, claiming negligence.[4]

"The Texas Supreme Court affirmed a partial summary judgment in favor of the doctor, agreeing with the trial court that proof of willful and wanton negligence was required, and that the doctor's conduct did not meet that standard," Silver explains.

One of the few malpractice cases that did succeed in proving gross negligence involved some unusually egregious circumstances. The physician defendant was on probation and subject to a disciplinary sanction imposed by the Texas Medical Board.[5]

"Hospital bylaws apparently prohibited physicians on probation from being on staff," Silver observes. "Other doctors on staff testified that the doctor was a problem." ■

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Hospitals Bracing for Litigation from Infected ED Providers

Hospitals expect plenty of litigation from emergency department (ED) providers who have contracted COVID-19, often while working without adequate personal protective equipment (PPE).[1]

Undoubtedly, some EDs will see more claims than others. "Most litigation arises from an emotional place. If there's a perception that the hospital was doing everything they could, there will be fewer claims," says **Domenique Camacho Moran**, JD, a partner at Farrell Fritz in Uniondale, NY.

The Coronavirus Aid, Relief, and Economic Security (CARES) Act offers liability protections for malpractice claims made by patients.[2] "However, there are no protections in the CARES Act as it relates to potential claims brought by employees against their employers," says **David E. Renner**, JD, an attorney who works on employment and employee relations for Post & Schell in Pittsburgh.

If hospitals can prove they followed generally accepted standards in the community and complied with federal, state, and local guidance, says Renner, "that should go a long way to help defend against these types of claims."

The following are some claims that ED nurses, ED staff, or emergency physicians (EPs) may bring against hospitals:

• Workers' compensation claims filed by employees who say they were infected with COVID-19 at work. One big hurdle for ED providers is that a workers' compensation claimant generally needs evidence of a work-related exposure. "The question will be, 'How do we know where they were infected?'" Moran explains.

Hospitals can counter that the virus is not just in their ED, it is everywhere in the community. "But this may not be an issue for many healthcare workers who are working directly with patients sick with the virus, because it may be clear that they contracted the virus at work," says **Sloane Ackerman**, JD, counsel in the New York office of O'Melveny & Myers and a member of the firm's labor and employment practice.

In addition, some states are making it easier for healthcare workers to apply for workers' compensation by creating a presumption that the employee contracted the virus on the job.[3,4] "It remains to be seen whether these laws will be enforced," says Ackerman.

Trade groups are fighting the expansions, arguing they will cause higher insurance premiums. The Illinois Workers' Compensation Commission repealed its "presumptive" rule, after a judge issued a temporary restraining order blocking the rule in response to a lawsuit filed by multiple business associations.[5,6]

Some EDs are seeing far more cases than the infection rate in the community at large. That kind of data could be used to support an employee's claim. "The more they can show that the infection happened at work and not at home or in the community, the higher the likelihood of the employees' success," says **Jonathan Sumrell**, JD, an attorney in the Richmond, VA, office of Hancock, Daniel & Johnson.

• Private personal injury lawsuits brought by ED staff. "Many of these cases will likely include a battle about the appropriate forum for these types of claims," Sumrell predicts.

After contracting Ebola while caring for an infected patient in 2014, an intensive care unit nurse sued the hospital. The lawsuit alleged the hospital provided inadequate guidance and training on what kind of PPE to wear, and failed to have appropriate policies, procedures, and equipment in place.[7]

Eventually, the case was settled, but whether the case could be tried in the courts (or whether workers' compensation was the only recovery possible) became an issue during litigation.

"The case is instructive in part because it shows where battle lines might be drawn in COVID-19 cases," Sumrell notes.

Certain ED staff may try to assert claims in court. Hospitals are going to argue that the claims should go through the workers' compensation system instead. "Healthcare workers may assert wrongful death or other tort lawsuits if they are exposed to COVID-19 while at work," Ackerman says.

The biggest hurdle is that in nearly all states, workers' compensation insurance is the only remedy for work-related illnesses.

"There are some narrow exemptions in certain states, such as if the employer engaged in an intentional wrongful act," Ackerman notes.

There are states that could allow claims to be brought in the courts if a hospital's conduct was particularly egregious. "An employee would have an uphill battle to successfully bring these claims in court," Sumrell observes.

ED providers would have to show the hospital's gross negligence resulted in their infection. "When confronted with claims of gross negligence, this is really going to be splitting hairs," Moran says.

One of the challenges is that guidance has shifted so dramatically. "What was right on March 10 might be somewhat different than April 20," Moran cautions.

Establishing exactly what policies the hospital was operating under on a particular date, or what supplies were available (or not) on that date could prove to be tricky. For instance, if an ED nurse alleges an infected co-worker was allowed to come back to work too soon, the outcome of the claim will hinge on what the guidance was at that point. For the hospital to defend itself, says Moran, "it is really important that someone is downloading guidance on a daily basis."

• Anonymous complaints filed by employees regarding workplace hazards. Under the general duty clause of the Occupational Safety and Health Act (OSHA), employers generally are required to provide "a place of employment ... free from recognized hazards ... likely to cause death or serious physical harm."[8]

"As such, if there are claims of inadequate PPE being provided by hospitals, those hospitals could be facing an OSHA investigation," Renner warns.

• "Failure to accommodate" claims under the Americans with Disabilities Act. These claims can come up if an ED provider with a physical impairment asked for special PPE, but the hospital never provided it.

"Employers are required to accommodate their employees' disabilities. That includes making accommodations in the use of PPE," Renner explains.

• Claims under the Families First Coronavirus Response Act. This contains anti-retaliation protections for employees who use allowable paid sick leave. If an ED provider is terminated or disciplined for doing so, says Renner, hospitals could face claims.

• Liability for violating employees' rights under the National Labor Relations Act (NLRA). Employers are prohibited from taking adverse actions against employees for engaging in protected "concerted activity."

Nationwide, ED nurses have protested being forced to work with inadequate PPE.[9] If an ED nurse was disciplined or terminated for taking part, says Renner, "the hospital could be facing liability for violating their rights under the NLRA." ■

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Enforcement Action Likely if Hospital Retaliates Against ED Staff

Some emergency department (ED) doctors and nurses allege they were disciplined or fired after complaining about inadequate personal protective equipment (PPE), or for refusing to treat COVID-19 patients without N95 masks.[1,2] "Depending on who the complaint was made to, and the specific complaint made, the hospital could have retaliation claims under OSHA [Occupational Safety and Health Administration] or state whistleblower protection laws," says **David E. Renner**, JD, an attorney who works on employment and employee relations issues for the law firm of Post & Schell in Pittsburgh.

At the federal level, OSHA prohibits employers from retaliating against employees who communicate with management about occupational safety or health matters, among other things.[3] In April, OSHA reminded employers that it is illegal to retaliate against workers because they report unsafe working conditions.[4] Additionally, OSHA issued an interim enforcement response plan with instructions regarding the handling of COVID-19-related complaints.[5] The plan says onsite inspections will prioritize high-exposure settings, which certainly includes EDs.

"This is an area that will likely see some enforcement focus by OSHA in the coming months," says **Jonathan Sumrell**, JD, an attorney in the Richmond, VA, office of Hancock, Daniel & Johnson.

If an ED nurse is fired the day after complaining about PPE, it certainly looks suspicious. That kind of timing helps the employee prevail in a retaliation claim. "Hospitals will need to thoroughly document why they took an adverse employment action," Sumrell stresses.

It always is possible the ED nurse was fired because of misconduct or budget cuts. If so, "documentation showing that decision-making process would be key for employers," Sumrell says.

Evidence substantiating the misconduct, and that the hospital followed its disciplinary policies, is helpful for the defense. "In no event should an employee's complaint be a factor in the decision to take adverse action against them," Sumrell underscores. "Employers are taking a huge risk if they don't heed that advice." ■

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No ICU Bed? ED Patients 'Fall into Black Hole'

Even emergency departments (EDs) that do not normally board admitted patients might have been forced to do so when the first surge of COVID-19 patients began taking up all the intensive care unit (ICU) beds in March and April.[1] This adds to the legal risks of this practice considerably, according to **Stephen Colucciello**, MD, FACEP. "If suddenly a third of ED patients are boarders, that's a very high-risk situation. There's lack of awareness of what is supposed to happen," says Colucciello, a professor of emergency medicine at North Carolina-based Atrium Health.

David Sumner, JD, has handled many cases involving ED patients waiting for an inpatient bed to become available. "Patients can fall into a black hole of poor or suboptimal management," observes Sumner, a Tucson, AZ, medical malpractice attorney.

A hospital is obligated to act reasonably, says **Gregory Dolin**, MD, JD, an associate professor of law at the University of Baltimore. If a patient is stuck in the ED because there are no ICU beds available, a reasonable hospital cannot change that fact. But if an admitted, boarded ED patient deteriorates, "that may be a malpractice issue," Dolin cautions.

The plaintiff can allege the emergency physician (EP) did not act as a reasonable doctor would. "The emergency physician must act reasonably under all the relevant circumstances," Dolin notes.

Coronavirus patients taking up all the available ICU beds clearly is a relevant circumstance. "That is nobody's fault," Dolin acknowledges. However, failure to prioritize care appropriately for the patient who remains in the ED is a different story.

"If a reasonable EP would have put person A into the ICU and not person B, that can be a med/mal issue," Dolin explains.

In terms of malpractice, the main question is going to be: Did the ED patient receive treatment as fast as he or she should have, given the relevant circumstances? "That applies to the real world, not a hypothetical make-believe world where you can get ICU admission at a moment's notice," Dolin notes.

EDs in known COVID-19 hotspots with long waits for ICU beds probably will be treated somewhat differently than smaller community EDs, where it was mostly business as

usual. "The law requires the judge and jury to take the circumstances into account," Dolin says. "How will they do that in the jury deliberation room is entirely unpredictable."

It largely depends on the evidence both sides present. That does not mean the EP has to (or should) meticulously document everything going on in the ED at the time.

"The goal is not to document in Patient A's chart what is happening to patient B — or in the ER in general," Dolin says.

If all ED charts are in good order, the records as a whole will tell the story. A picture emerges of what was happening in the ED at the time. "It depends on the quality of recordkeeping — or the quality of lawyering," Dolin reports. "Sometimes, it just depends on juries' idiosyncrasy."

Some malpractice claims for boarded ED patients happen because admitting orders were ignored. Antibiotics were not given, for instance, even though the patients spent many hours in the ED. "The ED nurses were used to following only those inpatient orders that were marked 'stat,' and by practice, left other orders to the inpatient nurses," Colucciello says.

In many claims involving ED boarding, "critical orders written by the admitting MD went unexecuted for a significant period." Floor nurses do not take responsibility for admitting orders until the patient is physically relocated. ED nurses say the floor nurses are the ones responsible for orders because the patient already is admitted.

A recent malpractice case involved delayed care of an ED patient who presented with acute pancreatitis. Admission orders for intravenous (IV) fluids were written 15 minutes later, but the patient stayed in the ED for three hours. During this time, the admitting hospitalist assessed the patient, but gave no verbal orders.

The ED nurses never gave the IV fluids. Only after the patient was transferred to the floor was the order carried out. During subsequent litigation, the ED nurse testified that it was not their responsibility to execute admitting orders. The floor nurses testified it was not their job to do so until the patient was physically transferred. "The case settled at mediation prior to any expert depositions," Sumner says.

The patient had already experienced substantial delays before going to a room. Once in a room, the patient waited even longer for an evaluation.

"There were delays on top of more delays to provide this patient with adequate fluid resuscitation," Sumner says.

Ideally, the admitting physician personally examines the patient in the ED. If not, says Sumner, "the ED staff may have a heightened duty to still vigilantly assess the patient awaiting a bed assignment and transfer." Even if the admitting doctor does see the patient in the ED, "the ED nurses are still responsible for executing proper orders and treatment until the patient physically leaves the ED," Sumner adds.

Until all of the following happen, EPs are potentially liable, according to Sumner:

- The patient has been accepted for admission;
- The hospitalist or admitting physician has written or entered admitting orders on the chart;
- The patient has been physically relocated to the floor.

Colucciello says there are a few ways defense attorneys can establish that the admitting team, not the ED team, was legally responsible for the boarded patient:

- **Certain specialty organizations specifically address this issue.** If transfer of admitted patients to inpatient units is delayed, the hospital must provide the supplemental nursing staff necessary to care for the patients boarded in the ED, according to an American College of Emergency Physicians (ACEP) policy.[1]

Another ACEP policy states that regardless of the location of an admitted patient within the hospital, the ultimate responsibility for an admitted patient's medical care rests with the admitting physician.[2] "Should an emergency occur, the EP should intervene," Colucciello adds. "But nonemergencies depend on the admitting physician."

- **ED nurses can contact the admitting team regarding all orders.** "That hands the baton to admitting, which is where it should rest," Colucciello offers.
- **There are hospitals that have instituted policies directing floor nurses to care for boarded ED patients.** It needs to be clear whether only "stat" orders are handled by ED nurses (and routine orders are handled once the patient is moved to the floor), or whether floor nurses will come to the ED to manage all orders.

"Ideally, ICU nurses would come down to manage boarded patients. But that does not happen very frequently," Colucciello says.

- **Hospital policies can directly address rounding on admitting patients in the ED.** "If in the ICU the patients are rounded on each shift, then ICU patients in the ED need to be rounded on with the same frequency," Colucciello says.

Even without a policy, ED leadership can secure an agreement from the admitting team that they will round on ED patients at certain intervals. "But it's not their usual practice," Colucciello notes. "What

happens is they hope the patient will come upstairs, and they will be able to do business as usual."

Orders for labs, diagnostic tests, pain management, and medications cannot just wait indefinitely. That means someone has to take action while the patient is in the ED. "The reality is that the patient belongs to admitting," Colucciello argues. "The patient just happens to be temporarily housed in the ED."

• EPs can clarify the exact time the admitting physician took responsibility for the patient. In the electronic medical record (EMR), the time stamp might indicate that at 4:42, the patient was admitted to Dr. Jones. That is when the admitting orders were put in, but the admitting physician actually verbally accepted the patient at 4:00 and saw the patient at 4:30.

The EP can bump up the time frame for when the admitting took responsibility by making a note of it. The EP might chart something like, "At 4:00, spoke to Dr. Jones, who agrees to admit the patient," Colucciello suggests. The plaintiff can argue the EP still was liable because something was missed, or because the patient was not stabilized adequately. "There are a lot of strategies that the plaintiff attorney will employ," Colucciello says.

In seeking to keep the EP in the case, the plaintiff attorney will scrutinize whether the EP knew the patient's condition was deteriorating and whether ED nurses told the EP the patient was in trouble. If the patient was in trouble, did the EP responded appropriately?

"We could still lose a case where the patient decompensates in the ED, but only for things we should have known about, and only where we failed to intervene appropriately," Colucciello says. ■

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Delayed Care, Misdiagnoses Still Happening, Regardless of COVID-19 Surges

Just because there are surges of respiratory patients in the emergency department (ED) does not mean there are any fewer stroke, heart attack, or septic patients.

There will not be fewer lawsuits, either, if any of these patients receive delayed care or are misdiagnosed, according to **John C. West**, JD, MHA, DFASHRM, CPHRM.

"The future of litigation can be summed up in one word, and that's 'tsunami,'" says West, principal at West Consulting Services, a Signal Mountain, TN-based risk management and patient safety consulting firm.

Remember the definition of medical malpractice, says **Kenneth N. Rashbaum**, JD: a departure from community standards of care that proximately causes injury or other damages. If an ED adhered to community standards during the pandemic, but delayed for a patient, says Rashbaum, "it would be difficult for a properly instructed jury to find liability against the caregivers."

Particularly egregious delays or misdiagnoses could result in verdicts for plaintiffs. "But those cases would be outliers," says Rashbaum, a partner at New York City-based Barton. In light of this reality, "the more responsible plaintiffs' law firms, who evaluate their cases well at intake, will be likely to decline cases in which ER delays during the pandemic are alleged," Rashbaum adds.

On the other hand, liability protections do not stop anyone from suing. "The courts have to allow these cases to go through the normal process," West says. "They can't circumvent things just because the situation was not normal at the time of the injury."

West says that, in general, courts do not take emergency situations into account when determining if medical malpractice cases can go forward. "The problem is, we haven't really had a situation like this since 1918. And in 1918, medical malpractice was virtually unheard of," West notes.

In this legal climate, ED claims are most likely to be successful if delays are such that it "shocks the conscience of a reasonable person," West observes. A good example of such a case is a recent malpractice lawsuit alleging a delayed evaluation of a patient with diabetic ketoacidosis. The patient was not given a medical screening examination, as is required by the Emergency Medical Treatment and Labor Act (EMTALA), for longer than 11 hours. "That was pretty egregious," West acknowledges. "The issue was whether the screening was appropriate if it was excessively delayed."

The vast majority of ED misdiagnosis cases West sees involve patients who were sent home, only to return a short time later in much worse shape. Those cases fall into two categories:

• **The diagnosis was not manifest at the time of the original ED visit.** "In those cases, almost invariably, the person is diagnosed with something relatively minor and comes back acutely or dangerously critically ill," West explains. This happens often with sepsis. "Sepsis is hard to recognize in its early stages," West admits. Patients initially present with some aches and pains, but are not overtly septic. In cases like this, "it's a toss-up as to whether there will be liability," West offers.

In one case, a woman presented with hip pain and a pimple on her cheek that turned out to be an abscess. "She was septic, but not in full-blown sepsis. That was an EMTALA case," West recalls. The patient was in the (intensive care unit (ICU) for four months, during which time both her legs were amputated below the knee, she lost the sight in one eye, and she developed severe and permanent lung damage. "The damages were capped by Virginia law at $1 million," West reports.

In a case with a similar fact pattern, a woman presented with an injured elbow from a fall injury, but without an open wound or fever. The woman was discharged with pain medication and an X-ray. It turned out the condition was necrotizing fasciitis; the woman lost her arm. Since that diagnosis would not be on a reasonable emergency physician's (EP) differential for an elbow injury, the EP was not held liable. "A reasonable EP would not do a blood culture if somebody injures their elbow," West adds.

• **The diagnosis is manifest at the time of the ED visit, but someone misses it.** "Those are pretty clear-cut negligence cases, and are very difficult to defend," West says. The plaintiff argues that had the EP complied with the standard of care and performed the appropriate tests, he or she would have made the correct diagnosis. If there is any delay in recognition of stroke, sepsis, or heart attack, says West, "juries don't want to hear excuses."

Jurors look specifically at the care that the patient received — whether it met the standard of care and, if not, whether the breach of the standard of care caused the injury. The COVID-19 pandemic does not change that, West stresses. "The fact that you delayed the diagnosis of a stroke patient because you were full of respiratory cases and had nowhere to put them is not going to be a defense," he cautions.

How well the EP handled the surge of cases is what is relevant. EPs cannot hire more staff, nor can they create more beds in the ED. "But they have to figure out how the make the best use of the staff and beds they do have," West underscores.

Plaintiff attorneys pursuing misdiagnosis cases will ask defendant EPs about their usual practices. EPs can expect this kind of question: "Do you normally see stroke patients with a door-to-doctor time of 30 minutes or less?" If the EP agrees that is the case, the next step is to corner the EP into agreeing that he or she considers this time frame to be the standard of care.

"Then, [plaintiff attorneys] will jump on the doctor and say, 'But in this case, you didn't see the patient for two hours,'" West warns.

EPs might start talking about the complete and utter havoc that existed in their department because of COVID-19. The plaintiff attorney can move to strike that kind of testimony as nonresponsive. "The plaintiff attorney will say, 'I am asking only about this patient,'" West explains.

In reality, the standard of care might well have been different at the time of the plaintiff's ED visit vs. "normal" times. "The standard of care is a very flexible thing. It is not carved in stone somewhere," West notes.

During depositions, EP defendants can testify that reasonable colleagues would triage the priority of all the different patients assigned to them. If the ED was full of COVID-19 patients at the time, says West, "the standard of care for normal circumstances goes out the window."

However, the entire defense cannot hinge on all the other respiratory patients the ED was seeing. This only serves to support the argument that the EP rushed through the evaluation of the patient whose care is at issue. "It could look like the doctor talked to the patient for a matter of seconds, and made a premature diagnosis without actually considering all the available evidence," West offers.

If a misdiagnosed patient experienced a terrible outcome, says West, "the hospital saying, 'We were so busy that we couldn't do X, Y, or Z' is not good enough. Once all the [COVID-19] panic subsides, it may no longer seem like it was such an emergency." The plaintiff attorney can argue, "We know you had a lot of patients. But you could have done better for this patient."

"The law has never dealt with a situation like this," West says. "This is new, and how the courts deal with it is anyone's guess." ■

COMING IN FUTURE MONTHS

- What new stroke guidance means for ED malpractice claims
- Some EPs have more than their share of malpractice lawsuits
- Lawsuits target incidental findings in admitted ED patients
- Successful defenses to allegations of delayed ED transfer

Psychiatric Patients Pose Unique Legal Risks During Pandemic

If an emergency department (ED) is packed with respiratory patients, psychiatric patients could end up boarded for hours or days. This is not good for patients, and creates liability exposure for EDs. "If somebody does fall through the cracks, there's potential for some really bad outcomes," says **Scott Zeller**, MD, vice president of acute psychiatric medicine at Vituity in Emeryville, CA.

Telepsychiatrists can help emergency physicians (EPs) with risk assessment, disposition, and treatment, says **Adrienne Saxton**, MD, an assistant professor of psychiatry at Case Western Reserve University in Cleveland. Even if a bad outcome occurs, the consult shows the EP took the case seriously by seeking specialist advice. "That makes it more difficult to prove the EP's care was negligent," Saxton explains.

Due to recent telemedicine waivers for COVID-19, EDs can access mental health professionals easier.[1] Previously, Medicare restricted this only to rural sites. Many urban EDs also needed teleconsults. "It always made sense for multiple settings. It should never have been restricted to rural settings. But that was all Medicare was permitting," Zeller observes. For now, telehealth is making it possible to better use the limited number of psychiatrists available to EDs. "Unfortunately, sometimes it takes a crisis for something to become obvious to the powers that be," Zeller notes. There are no current published data showing that higher numbers of patients with psychiatric conditions are presenting to EDs during the pandemic. "However, some predict a mental health crisis in the wake of COVID-19," Saxton says.[2]

There are many reasons, including more domestic violence, massive unemployment, financial problems, and difficulty accessing outpatient care. If litigation against EDs arises alleging negligent care of psychiatric patients, there are some factors likely to become an issue:

• Some states have enacted liability protections for healthcare professionals during the pandemic, but psychiatric care is not specified.[3] "One important question is whether all types of ED care would qualify, including psychiatric services," Saxton says.

• Expert testimony would be required to establish the hypothetical standard of care for a psychiatric patient in an overwhelmed ED during a pandemic. "As in other malpractice cases, experts on opposing sides may disagree," Saxton says.

• Arranging dispositions for patients with mental health and substance use concerns has become harder. Certain substance use treatment programs, intensive outpatient programs, and community mental health agencies have closed. Others switched to phone or virtual sessions.

Concurrently, group homes, nursing facilities, state hospitals, and other inpatient psychiatric units are increasingly scrutinizing admissions to prevent COVID-19 outbreaks. "Psychiatrists and social work teams can help overwhelmed emergency department physicians navigate these challenging issues," Saxton says.

• Despite liability protections that are now in place, there are continued legal risks for EPs if a psychiatric patient is discharged and harms themselves or others. "Liability for patient violence is a complicated area of law," Saxton says. Many states have enacted statutes addressing this, due to the well-established difficulty in predicting violence risk.[4] "These may protect against liability," Saxton observes. Some statutes offer immunity for patient violence where there was no explicit threat, but how much protection varies. Also, certain statutes are specific to mental health professionals. "How much protection would be offered to ED physicians who are conducting mental health evaluations depends on a state's specific definition of a mental health professional," Saxton notes.

Statutes are subject to interpretation by courts. This means EPs could be held liable for violence that was reasonably foreseeable, even in the absence of overt threats. "ED physicians generally know how to manage patients making explicit threats of violence," Saxton explains. Most EPs would consult psychiatry and/or arrange for inpatient psychiatric hospitalization for these patients. EPs probably face greater liability exposure for a different group of patients: those who do not make explicit threats, but remain at acutely elevated risk. "This may go undetected," Saxton adds.

A good example is a case involving a young man brought to the police for barricading himself in his basement due to paranoid delusions. The patient's history included schizophrenia, violence, and treatment non-adherence. "If he is calm in the ER, minimizes his situation, and promises to restart his medication, the EP may be tempted to discharge the patient," Saxton says. However, this patient clearly is at elevated risk of acting violently. "If a bad outcome occurs after discharge, the ER physician is at risk of liability, especially if he did not seek specialist consultation," Saxton says. Saxton recommends EPs

consider a consult to psychiatry (for risk assessment and disposition) in these specific situations: patients with active psychotic symptoms, patients with agitation or mania, patients with some evidence of suicidality (e.g., recent suspicious ingestion or injury), patients who engaged in a recent violent act or have violent fantasies (despite denial of current plan or intent for violence), and patients with a psychotic disorder who present with medication side effects that necessitate a significant change in their treatment plan. "These changes could exacerbate symptoms and acutely elevate risk of violence," Saxton reports. ED charts often contain the words "patient denies suicidal/homicidal ideation." This probably is not sufficient to justify discharging the patient.[5] "If there are other factors going on that raise concern, consider a consult to psychiatry to investigate further," Saxton says. This may reveal previously unknown risk factors, such as a suicide note or escalating substance abuse. "Sometimes, the patients most in need of psychiatric assistance deny or minimize their symptoms in order to be discharged," Saxton adds. ■

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Liability Protection Not Absolute for ED Volunteers

Emergency physicians (EPs) serving as volunteers during the pandemic have broad liability protections under the Coronavirus Aid, Relief, and Economic Security (CARES) Act.

"These are not absolute protections," notes **Leslie Isaacman Yohey**, JD, MBA, an attorney in the Memphis office of Baker Donelson.

Generally, gross negligence is never excluded from liability. "Simply because these liability protections exist does not mean that providers won't get sued," Yohey adds.

She recommends volunteer emergency department (ED) providers verify their malpractice insurance covers voluntary service. Hospitals should check that volunteer providers are covered under the hospital's malpractice insurance. Additionally, leaders should look to relevant state law to determine the extent of liability protections related to volunteers.

"In addition, protections may not extend to care provided to non-coronavirus patients, even though such care may be directly impacted by the pandemic," Yohey offers.

The issue of liability for volunteer physicians during an emergency is "widely misunderstood, with many unfounded concerns about potential liability," says **Mark A. Rothstein**, JD, director of the Institute for Bioethics, Health Policy, and Law at the University of Louisville. "Anecdotally, I know there is concern about liability. Those extremely concerned don't volunteer."

Hospital administrators also are worried. "Hospitals also may have some concerns, but that is why they have malpractice insurance," Rothstein notes. In addition to protections under the CARES Act, several federal and state laws grant immunity from malpractice liability to volunteer physicians in an emergency. One example is the Uniform Emergency Volunteer Health Practitioners Act. This protects volunteer health practitioners from damage liability, except in those cases of willful, wanton, grossly negligent, reckless, or criminal conduct, or an intentional tort.

"One reason these laws were enacted is the erroneous belief that there have been many lawsuits filed against healthcare providers for harms caused during a public health emergency," Rothstein observes. "In fact, there have been zero such lawsuits."

If a malpractice case were brought, a different standard of care could apply. "Many physicians are concerned that they would be held to the regular standard of care, which they could not meet because of the extraordinary conditions," Rothstein says.

However, the law in every state is clear on this point: A healthcare provider's duty is to do what is expected of a reasonably competent practitioner acting in the same or similar circumstances. "Thus, physicians rendering care without electricity, sterile supplies, or medicine are not held to a higher standard of care," Rothstein says. ■

ED LEGAL LETTER™

CME/CE QUESTIONS

1. **Which is true regarding hospitals' liability for emergency department (ED) providers who contracted COVID-19 on the job?**
   a. The CARES Act shields hospitals from exposure to claims brought by ED staff.
   b. Employees cannot recover under workers' compensation because there is no way to conclusively prove the infection was contracted at the hospital.
   c. Some states are modifying rules so infected workers are presumptively eligible for workers' compensation.
   d. Failing to provide appropriate personal protective equipment generally constitutes gross negligence, regardless of extenuating circumstances.

2. **Which is true regarding malpractice claims and the gross negligence standard?**
   a. State immunity protections enacted due to the COVID-19 pandemic are required to include gross negligence.
   b. Plaintiff attorneys can allege gross negligence instead of ordinary negligence to pursue claims despite enacted liability protections.
   c. Pleading gross negligence bars plaintiffs from recovery of punitive damages.
   d. Cases alleging gross negligence are less likely to survive if another healthcare provider involved in the care supports the plaintiff's allegations.

3. **Which is true regarding malpractice risks involving ED patients waiting for an intensive care unit (ICU) bed?**
   a. Boarding admitted patients due to no ICU beds available constitutes negligence on the part of the emergency physician (EP) and the hospital.
   b. Jurors will be instructed not to take availability of resources into account when determining negligence.
   c. EPs are expected to document specifics on volume surges to show why a patient waited for an ICU bed.
   d. Liability will depend on whether the ED patient received treatment as quickly as he or she should have, given the relevant circumstance.

4. **Which is true regarding legal risks of psychiatric patients presenting to the ED?**
   a. EPs generally cannot be held liable for a bad outcome if they specifically document "patient denies suicidal/homicidal ideation."
   b. Despite liability protections that are now in place during the pandemic, there are continued legal risks for EPs if psychiatric patients are discharged and harm themselves or others.
   c. EPs have liability immunity in cases in which there was no explicit threat.
   d. Teleconsults are linked to malpractice allegations of inadequate assessment.

CME/CE OBJECTIVES

After completing this activity, participants will be able to:

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