THE SULLIVAN GROUP

TSG NEWSLETTER

SAVING LIVES - REDUCING RISK

From The Editor

Fall is here, and it's time again to visit our colleagues at the ACEP Scientific Assembly. I'm looking forward to visiting with many of you there! Stop by our **Booth #825** and say hello.

We have not looked at EMTALA (Emergency Medical Treatment and Labor Act) in some time, and there are some interesting recent cases with great teaching points. The case we present in this issue is very relevant, as we rely more and more upon evidence-based medicine, protocols and algorithms to drive quality emergency care, reduce variability, and hopefully improve patient outcomes.

As evidence-based medicine increasingly guides treatment decisions through guidelines, algorithms and protocols, it is interesting to consider how a federal court considers the failure to follow those guidelines and protocols with regard to the medical screening exam. If your hospital has a chest pain or sepsis protocol and you do not follow it, could a patient claim that you and the hospital have violated EMTALA for failing to adequately screen a patient? For example, what if both the physician and the nurse fail to order a serum lactate required by your department's evidence-based sepsis protocol? What if you fail to perform a lumbar puncture on a febrile 10-day old child consistent with your department febrile child protocol?

EMTALA requires that medical screening should be similar for patients with similar complaints or presentations;

In This Issue...

Great News

The American Board of Emergency Medicine **(ABEM)** has affirmed that the TSG **RSQ® Clinical Assessment** (EMRI Audit) can be used by ABEM certified physicians toward fulfillment of a current ABEM Maintenance of Certification of Practice Performance (APP) – Practice Improvement (PI) requirement.

"Physicians certified by the American Board of Emergency Medicine may satisfy one current Assessment of Practice Performance requirement by completing this activity."

If you practice at one of the 400 EDs that currently use the **RSQ® Clinical Assessment** (EMRI Audit), please contact TSG or ABEM to learn more about how this activity meets the Assessment of Practice Performance Maintenance of Certification requirement.

If you are interested in implementing the **RSQ® Clinical Assessment** at your facility, please contact Brant Roth for more details.

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ABEM
www.abem.org

to put it another way, medical screening for patients with similar complaints cannot be disparate. So consider those issues in this case where a woman presented in her third trimester of pregnancy. The hospital had a policy on how vaginal bleeding in the third trimester should be evaluated and managed, and the emergency physician did not follow it. ■

Case Review

On January 4, 2007, plaintiff Hazel Cruz-Vazquez arrived at the Mennonite General Hospital (Mennonite) emergency department complaining of vaginal discharge and blood spotting but no pelvic pain. She was in her third trimester of her first pregnancy. The on-duty emergency physician (EP) performed only a pelvic exam and found that Cruz-Vazquez was not dilated. He consulted with her obstetrician, who advised the EP to administer some medications and discharge the patient, all of which the EP did. He discharged Cruz-Vazquez less than two hours after her arrival.

Editor's Note: *The formal case summary does not indicate what the hospital protocol on third trimester vaginal bleeding required. But in noting that the physician performed* ***"only a pelvic exam,"*** *it is likely that the hospital protocol required some type of fetal monitoring and evaluation for progress of labor - perhaps a pelvic ultra-*

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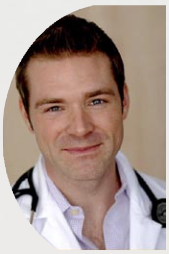
Meet Members of our RSQ® Advisory Board
at the upcoming trade shows

Obstetrics
Henry Lerner, MD

ASHRM, Booth #601

Disclosure and Apology
Doug Wojcieszak

ACEP, Booth #825

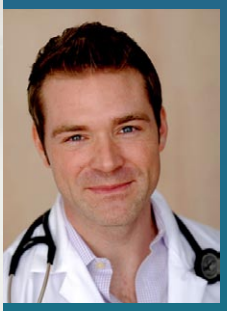


Patient Satisfaction
Doug Finefrock, DO

ACEP, Booth #825

Patient Satisfaction Is Here
What's Your Plan?

It has been a common belief that "Happy patients don't sue" and some organizations have relied on this as their risk management strategy. Furthermore, now that reimbursements have been tied to patient satisfaction scores, physician groups and hospitals have become even more invested in finding solutions that truly make a difference in their patient satisfaction metrics.



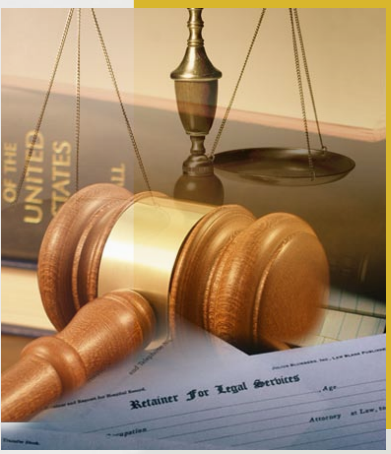
TSG has responded by developing a new Patient Satisfaction program called *Patient*SET™ "**S**atisfaction **E**very **T**ime." Championed by Dr. Doug Finefrock, *Patient*SET™ looks to the literature to identify certain elements of behavior that patients would like to see displayed during the physician / patient encounter. Delivered through an online course series, Dr. Finefrock uses multimedia videos to provide concrete examples that will help improve the patient experience.

In true TSG fashion, *Patient*SET™ extends beyond online education to include a real-time 'checklist' for the provider (*Patient*SET™ List) as well as an observational assessment tool (*Patient*SET™ Assessment) to be used by a case manager to analyze the clinician's compliance with key behavior elements of the visit.

If you are interested in learning more about the new *Patient*SET™ Program, please contact:
Brant Roth at broth@thesullivangroup.com

sound. In this case, the hospital actually stipulated that it had a relevant screening protocol for female patients who presented with vaginal bleeding in their third trimester and that it failed to activate that protocol for Cruz-Vazquez. The hospital policy was labeled "Gravid with 3rd Trimester Bleeding."

On January 6th, Cruz-Vazquez saw her obstetrician, who performed another pelvic exam; he diagnosed her as suffering from an incompetent cervix and recommended transfer to another hospital, to which Cruz-Vazquez agreed. She was transferred "in stable condition" that same morning and underwent a Cesarean section. Her baby died on January 7th for unspecified reasons. Cruz-Vazquez filed a complaint in the U.S. District Court alleging that Mennonite violated EMTALA by failing to screen her appropriately during the ED visit on January 4th and failing to stabilize or properly transfer her before she was discharged.



The trial court dismissed Cruz-Vazquez's complaint, finding that it stated facts that were limited to a medical malpractice claim. The appeals court

NEW e-Learning Courses

Patient Safety & Risk Management

- 11 Simple Strategies to Prevent Medication Errors
- Communication Strategies to Improve Patient Safety in High-Risk Situations
- Essentials of Patient Safety
- Handoffs, Transitions & Discharges: Key Moments in Patient Care
- Prevention of Medical Errors
- Technology Revolution: Improving Patient Safety, Reducing Liability

Hospital Medicine

- Anatomy of a Medical Negligence Lawsuit
- Myocardial Infarction Part 1
- Myocardial Infarction Part 2
- Pulmonary Embolism Part 1
- Pulmonary Embolism Part 2
- Risk & Safety Overview Part 1
- Sepsis
- Thoracic Aortic Dissection

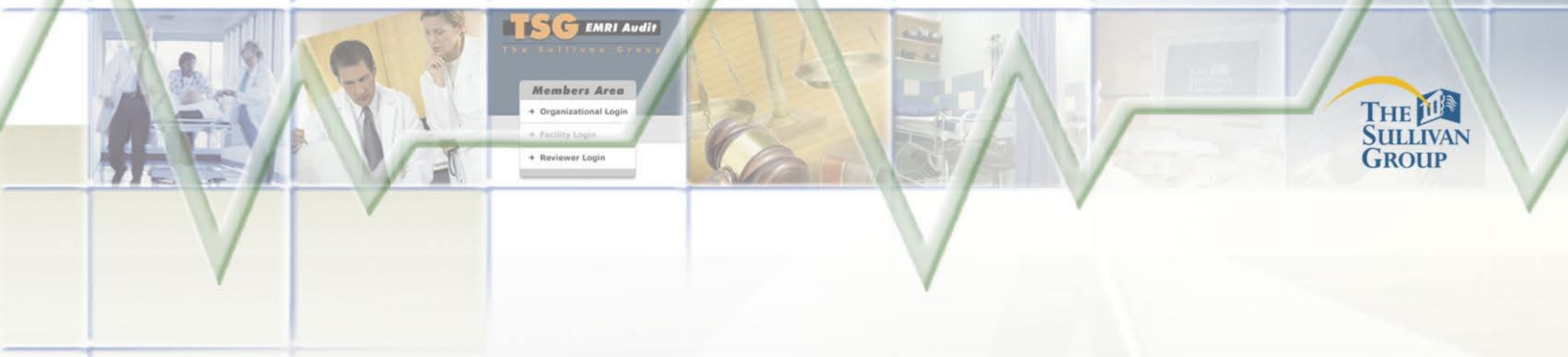
Toxicology

- Gastrointestinal Decontamination in Toxic Ingestion
- Opiate Agonists & Antagonists

Disclosure and Apology *(coming soon)*

- Disclosure & Apology: Fundamentals
- Disclosure & Apology: Just-In-Time Trainer

Click on the course name to see the course description.



(First Circuit) overturned that judgment and remanded the case for trial, as it believed that the 'following of protocol' issue was a genuine issue of material fact as to whether Cruz-Vazquez was adequately screened during the January 4th emergency department visit.

Noting that EMTALA does not define an appropriate medical screening, the appeals court in an earlier decision had defined appropriate medical screening as one "reasonably calculated to identify critical medical conditions that may be afflicting symptomatic patients and provides that level of screening uniformly to all those who present with substantially similar complaints. The essence of this requirement is that there be some screening procedures, and that it be administered even-handedly."

In this case, Mennonite stipulated that it had a relevant screening protocol for female patients who presented with vaginal bleeding in their third trimester and that it failed to activate that protocol for Cruz-Vazquez. In light of this stipulation, the appeals court focused on the trial court's failure to analyze how the case law distinguished between a hospital's failure to follow a regular screening protocol, as in this case, and prior similar EMTALA cases that involved 1) a screening protocol that was not followed because no identifiable symptoms triggered the need for such screening, or 2) that a screening protocol was followed but resulted in an improper diagnosis.

Appellate courts are required to determine if a fact pattern falls in line with prior cases in the jurisdiction and also searches other circuits to find similar cases for guidance. In one such case, a hospital defendant's only standard screening policy was a general one requiring "the taking of all presenting patients' complete histories." That very general policy statement provides little guidance on exactly what a screening exam should entail. The case (Reynolds) involved allegations of an EMTALA screening violation through inadequate history-taking. The court dismissed the case noting, "Absent a more detailed hospital policy the facts are

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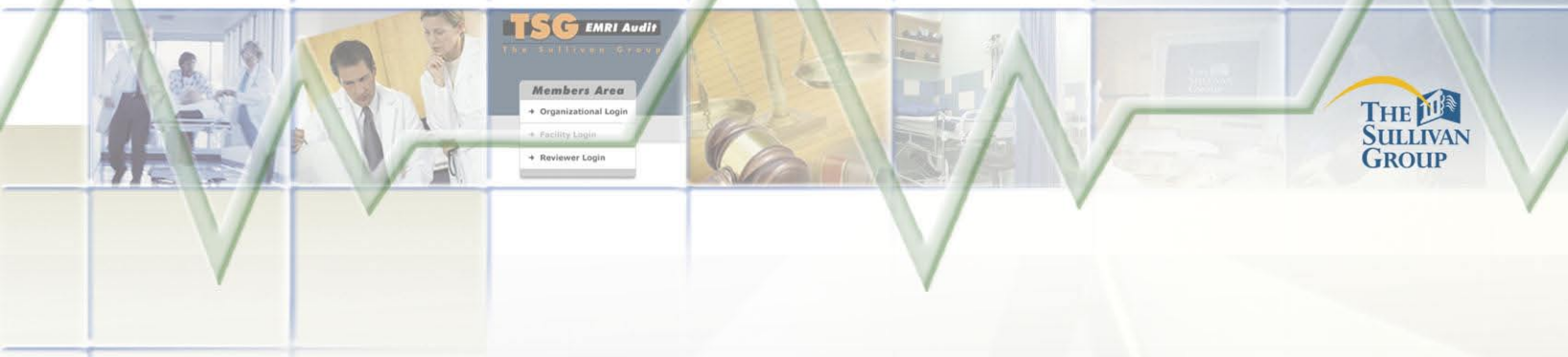

ACEP Speaker of the Year

Our own Dr. Dan Sullivan has been selected as **ACEP's 2012-13 Outstanding Speaker of the Year** in recognition of his excellence in teaching during ACEP educational meetings throughout the year. Participants in sessions taught by Dr. Sullivan rated his performance, versatility, and dependability as exemplary. Please join us in congratulating Dr. Sullivan for this achievement!

TSG Upcoming Lectures

by Dan Sullivan, MD, JD, FACEP

ACEP Scientific Assembly

1. **GOTCHA! The Medical Chart: Anticipating the Lawyer's Review**
   Mon., Oct. 14 @ 11:30 a.m.
2. **"Oh My Aching Head": High Risk Neuro with Jordan Bonomo**
   Mon., Oct. 14 @ 3:30 p.m.
3. **Medical Liability in the Age of Electronic Health Records**
   Tues., Oct. 15 @ 9:00 a.m.
4. **Critical Care and Critical Timing Requirements in the ED: What's Your New Liability?**
   Tues., Oct. 15 @ 1:30 p.m.

insufficient to find the patient received materially different screening from other similarly situated patients." In this case, however, Mennonite's policy "straightforwardly set forth a series of testing requirements in its 'Gravid with 3rd Trimester Bleeding' protocol for all patients presenting a specific set of symptoms."

The First Circuit also distinguished a second case (Vickers) where the patient had "hidden conditions" that resulted in a failure to diagnose and death. The Vickers court held that the patient received screening that would have been provided to other similarly situated patients. In the Cruz-Vazquez case, however, Mennonite staff was not blind to any hidden conditions, so her evidence pointed not to Mennonite's failure to prop-

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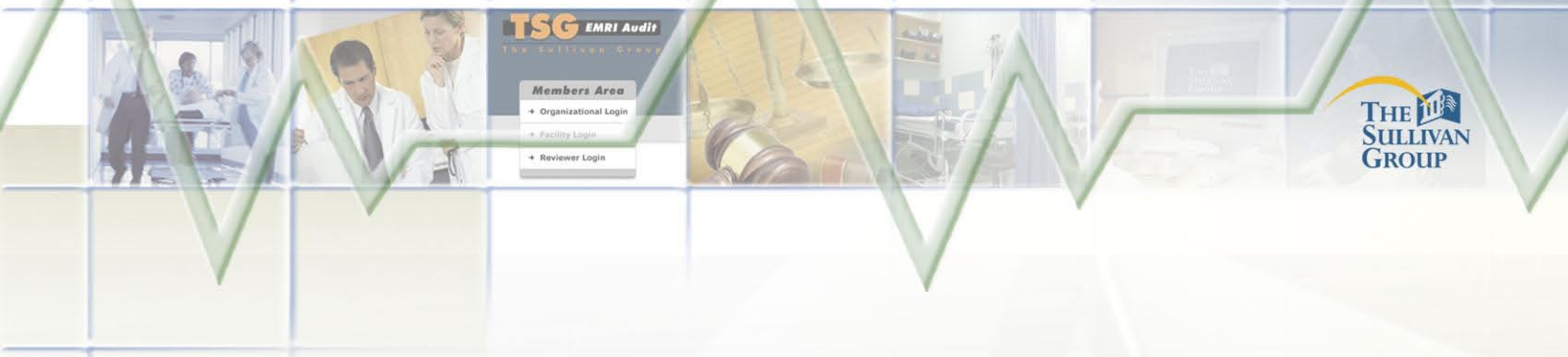
If you'll be at the ACEP Scientific Assembly, stop by and ask us about our risk and safety system solutions

Visit us at Booth # 825 at ACEP



erly diagnose based on a faulty screening, but rather a failure to treat her equally to others who were perceived to have the same condition.

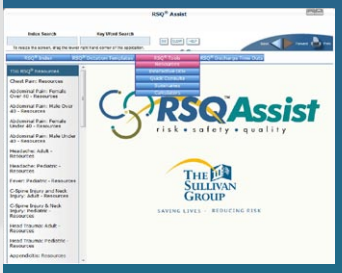
It is important to note that one circuit's opinion on a subject does not make it the 'law of the land.' However, this court raises a very important issue for emergency physicians. If a hospital has a protocol for evaluating a patient, does that become that hospital's standard for medical screening? If the emergency physician does not follow that protocol, isn't that a violation of the screening requirements under EMTALA?
The answer is - Maybe!

The federal appeals court reversed the trial court's decision in this case and decided that the court erred when it concluded that a physician's medical judgment may substitute for a hospital's internal protocols for the purposes of meeting EMTALA's appropriate screening requirements. It reversed the court's grant of summary judgment to the hospital and remanded for further proceedings on the EMTALA screening claim.

Since the appellate (First Circuit) court reversed the trial (district) court's decision, the patient who lost at the trial court tried to win at the appellate level. The patient asked for summary judgment, which is basically a win. The court noted that the evidence was unclear as to whether the emergency physician may have been justified in treating her

Do You Or Your Physicians Feel Vulnerable Documenting On An EMR?

TSG Has a Solution: RSQ® Assist



Many Emergency Medicine physicians are being forced to use an EMR that does not support their clinical practice or include **TSG's Risk Mitigation Module.** In response to their frustration, TSG has redesigned its clinical decision support library that is currently installed in over 400 EDs to create **RSQ® Assist**.

The patented **RSQ® Assist** application is a free-standing, complaint-specific clinical decision support tool that assists providers in their clinical practice and documentation.

- EBM Resources
- Quick Consults
- Interactive DDx
- Dictation Templates
- Medical & Clinical Calculators
- Chief Complaint-Specific Clinical Resources

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Brant Roth at broth@thesullivangroup.com

differently from other patients with like symptoms. The court's point was that the presence of a protocol could determine the standard for a medical screening exam

under certain circumstances. Those circumstances were not explored at the trial court, and the appellate court remanded the case for analysis of those facts.

The appeals court cautioned: "While a treating physician's medical judgment may inform whether or not a patient was sufficiently 'like' other patients that come under a given hospital protocol, it should not be improperly relied on to entirely bypass the hospital's obligation to equally screen under the statute."

Comments and Recommendations

1. EMTALA requires medical screening examinations for patients presenting to the nation's emergency departments requesting care.
2. After 25 years of EMTALA, it is clear that patients with similar presentations get similar medical screening exams. The point is to avoid discrimination among patients. This part of the law has been very effective - no disparate treatment.
3. If there are no department protocols, the courts have no guidance but to look at prior case law in their own jurisdiction as well as others.
4. If there is a protocol that addresses initial evaluation, then the courts will look to that protocol for guidance. If the presentation fits the protocol, the courts are likely to decide that is what is expected for screening. The failure to follow that protocol will be strong evidence of disparate treatment.
5. Emergency medicine is beginning to work toward an evidence-based approach toward patients, as are most other specialties. The evidence-based analysis typically manifests as a department protocol or order set.
6. Medical screening consistent with protocol is consistent with the courts' interpretation of proper medical screening under EMTALA. Medical screening that is not consistent with the protocol may be deemed disparate and not consistent with the courts' interpretation of EMTALA.
7. Emergency physicians may sometimes deviate from protocol for good, sound clinical reasons.
8. When a protocol exists and there is deviation from the protocol, consider documenting the reasons for the change in management in the medical record. It

may not always be appropriate to do so, but when it is, include it in the record.

9. Educate the ED team when protocols are developed and stress the importance of sticking to protocol unless there is a sound reason not to.

The ultimate goal is high-quality emergency care with EMTALA compliance as a by-product. An important by-product!

In this case, the emergency physician may have had a telephone discussion with the obstetrician; together they may have decided that the case was not consistent with or covered by the protocol, so they followed a different path. That would obviously be medically okay. The problem here is that the trial court did not elicit enough facts to know exactly what happened, and without that additional information, the appeals court could not uphold the decision. Thus, the appeals court sent the case back to the trial court to figure out exactly what occurred. If the trial court finds that the case fell within the reach of the protocol, the appeals court has let the trial court know that this would be a violation of the screening requirements under EMTALA. ■

Correa v. Hospital San Francisco, 69 F.3d 1184 (1st Cir. 1995)

Cruz-Vazquez v. Mennonite Gen. Hosp., No. 11-2297 (1st Cir. May 29, 2013)

Reynolds v. Maine General Health, 218 F.3d 78 (1st Cir. 2000)

Vickers v. Nash Gen. Hosp. 78 F.3d 139 (4th Cir. 1996)

TSG will be at the IMAC Cayman Captive Dec. 3-5

Contact Brant Roth to set up a meeting with Dr. Sullivan or Dr. Lerner

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