President’s Message

Linda De Feo, MD, JD, FACEP, President

One rare night, meaning there weren’t 15 patients in the waiting room clamoring to be seen, 4 ambulances lined up in the back hall, and 2 simultaneous codes, I was talking with one of the EM residents. A doc he knew was named in a lawsuit, and he wanted to know what happens when you get sued. Well, I told him, when I started out in Emergency Medicine 20+ years ago, you rarely heard of an “E.R.” doc being sued. Frankly, no one knew who we were. Now we are on T.V., in the news, and the primary care physician to millions of Americans. Our reward for this is to become a recognizable target for malpractice attorneys! Unless you’ve been living in a cave, you know that the cost of malpractice insurance has skyrocketed. Several large companies have gone bankrupt, and many specialists have removed themselves from on-call lists, and restricted their practices to limit liability exposure. Of course, this wasn’t his question, so after my soapbox tirade, I explained to him what happens when you get sued in Maryland.

A malpractice action must be brought within 5 years from the date of the occurrence, or 3 years from the date when the injury was discovered, whichever is earlier. This is known as the statute of limitations. The rules are different for minors. A court decision on October 8, 2002 held that the statute does not begin to run until the child reaches age 18.

Within 90 days of filing a claim, the claimant must file a certificate from a qualified expert attesting that not only did the physician deviate from the standard of care, but that that deviation was the cause of the alleged injury.

The next step may, or may not, be arbitration. Maryland used to have a mandatory, but non-binding, arbitration rule. This meant that all cases had to be heard by a review board before proceeding to trial, but the decision was not binding on the parties. At this time, arbitration can be waived by either party and is the exception rather than the rule.

After this comes interrogatory and deposition. An interrogatory is a series of written questions submitted to you by the attorney and must be answered in writing. A deposition is testimony under oath which is transcribed verbatim and used during trial. Even though we, as emergency physicians, are trained to be cool under fire, this can be an intimidating experience. Be careful what you say during this process, and remember that your only friend is your attorney. I don’t care if the plaintiff’s attorney volunteers for habitat for humanity, or looks like your mother, they are not your friend. Also consult with your attorney before talking with hospital council. Unless you are both under the same malpractice policy, they may not be your friend either. In Maryland, a hospital can be held responsible for negligent acts of independent contractors in the Emergency Department. They are almost always named in any malpractice action against an emergency physician. So on the one hand, it is in everyone’s best interest to maintain a united front, but on the other, given the doctrine of Joint and Several Liability (explained below), the more defendants the better!

Joint and Several Liability means that if the case is settled, or is won in trial, all named defendants share the cost equally. This can be good or bad depending on what actually happened. If a case against you, the hospital, and the private attending settles for 3 million, but you were only minimally at fault, you still pay 1 million.

We do have a few protections. For example, Maryland still has a contributory negligence standard where any negligence by the claimant will bar their recovery. The best thing we have going, however, is the non-economic damage cap. This was set at $500,000 in 1994 and goes up by $15,000 each year. At this time, the maximum is $620,000. This is very generous, particularly when compared to other states with caps of $250,000 to $350,000. The trial lawyers are
The Legal Corner: Vital Records
Larry Linder, MD, FACEP

In the last EPIC we started a new section called “The Legal Corner.” This section includes clinical scenarios that emphasize some of Maryland’s pertinent or unique laws and regulations. These questions have a clinical focus and are in medical language, not legal language. In the Emergency Department, I frequently hear statements spoken with authority and with the assurance that Maryland law requires this or prohibits that, only to find that there is no such law or that the regulations being referred to have been hopelessly extrapolated to a preposterous extent. This section should help everyone in the emergency department perform their daily job. For that reason, I am asking anyone who has a question, area of confusion, or a concern to please submit it for future EPICS. Please send your questions or comments to Claire Jefferson at MDACEP@AOL.COM or to Maryland ACEP, 1211 Cathedral St., Baltimore, MD 21201 c/o Lawrence S. Linder, MD.

As you read the questions and answers below please remember that law, like medicine, is “not an exact science.” Laws are interpreted by different lawyers in different ways. We have even seen situations where the same lawyer interprets a law in two different ways when asked the same question a month later. Sometimes one law is in conflict with another or with a state regulation. At other times federal laws are passed which take precedence over state laws. Please use these scenarios as a guide, but consult with your hospital’s attorney for more information. This issue will deal with Vital Records.

VITAL RECORDS

1. A patient arrives in the ED with CPR in progress and can not be resuscitated. The patient has a history of terminal cancer but the patient’s attending physician refuses to sign the death certificate and asks you to do it.

   Is it your responsibility?

   The statute defines Attending physician as “the physician in charge of the patient’s care for the illness or condition which resulted in death.” In another section, the law says that the death certificate must be filled out by the physician who last attended the deceased.

   This refusal to sign may be characterized as a turf battle. Practice varies from location to location, but in many Maryland Emergency Departments the emergency physicians do not sign the death certificates. If the state adopts electronic filing, it will be easier for the private physician to sign the death certificate in a timely manner.

   If you are not comfortable signing the death certificate, what are your other options?

   Depending on your interpretation of the law and your desire to maintain good relations with the physicians who practice in your hospital, you may decide to just fill out the death certificate. However, you only know that the patient was not able to be resuscitated. You may not be in the same position to verify the primary cause of death which may have been cancer, a chronic neurologic problem, etc.

   There are other options. An associate or partner of the treating physician can sign the death certificate. The chief medical officer of the hospital in which the patient died can sign. The physician who performs an autopsy, if one is performed, can sign. The next question will list another option.

2. A patient arrives in the ED with CPR in progress and can not be resuscitated. The patient has been healthy and the attending physician does not know the cause of death. He asks you to sign the death certificate since you just cared for the patient.

   Is it your responsibility?

   A physician who is responsible for filling out a death certificate shall promptly notify the medical examiner if the deceased was not under the care of a physician during the terminal illness, the cause of death is unknown, or the physician considers the condition causing or contributing to the death to be one of the following:

   - an accident, including a fall with a fracture or other injury,
   - homicide,
   - suicide,
   - other external manner of death,
   - alcoholism, or
   - criminal or suspected criminal abortion.

   You should refer the case to the medical examiner because you do not know the cause of death. If the medical examiner is not able to determine the cause of death within 24 hours of receiving the body, the examiner shall enter "investigation pending” in the cause of death section of the death certificate. As soon as the medical examiner discovers the cause of death, s/he shall report the cause to the Division of Vital Records.

3. You call an attending physician to sign a death certificate for her patient and she says she is about to leave on a three (3) day vacation.

   Can she sign the certificate when she returns?

   No, the statute says the physician must sign the certificate within 24 hours of having received it.

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Can she delegate the task to her partner?
Yes, as mentioned above, this task can be delegated to a partner/associate.

4. Can the cause of death be cardiopulmonary arrest or failure?
There has been an effort to decrease the use of this term on death certificates if another more proximate diagnosis was the cause of the cardiopulmonary arrest. While cardiopulmonary arrest is the usual final common pathway in all deaths, more commonly there is another cause. This is important to document on death certificates for epidemiologic reasons. However, if you only know that the cause of death was inability to restart the heart and you are the one who has to fill out the death certificate, there is no law preventing you from recording that as the cause of death.

5. While working in the ED, you deliver a patient’s healthy baby boy. You have worked five days straight and you are now off for three. You live an hour away from the hospital. You receive a call from a hospital administrator stating that you must return immediately to sign the birth certificate. Are you legally obligated to go immediately?
No, Maryland statute allows 72 hours after a live birth to sign the birth certificate. Individual hospital bylaws, however, may stipulate a shorter time.

What is the penalty if you do not comply?
A person who violates this law may be guilty of a misdemeanor and may be subject to a fine of $100 to $1,000 and imprisonment not exceeding one year or both. There would likely be departmental and hospital repercussions, as well.

Your hospital always types the birth certificate before it is signed. Could you have legally written in the details and signed the certificate before you left the hospital?
Yes. In the preparation of birth, death and fetal death certificates, all of the information requested must be typed or written plainly in black, non-fading ink.

Could you have signed a blank certificate and allowed the administrator to type in the details later?
No, because you would not be able to verify that the typed insertions were true and correct.

6. A woman delivers a baby in the ambulance on the way to the hospital. Both the mother and child are healthy when they arrive. Who is responsible for filing the birth certificate, you, the woman’s obstetrician, or the medic in the ambulance?
None of the above. If a child is delivered outside of a hospital, it shall be certified by the local health officer in the jurisdiction where the birth occurred.

7. A forty-two year old woman who says she is 19 weeks pregnant presents to the ED with abdominal pain and vaginal bleeding. While you are caring for her, she has a miscarriage. You deliver the fetus and there is a heartbeat. Your attempts at resuscitation fail. Is this a fetal death since the gestation period was only 19 weeks, or is it a live birth? Which form needs to be filed?
A fetal death is defined as the death of a fetus which does not breathe or show any signs of life, such as heart beat, pulsation of the umbilical cord, or definite movement of voluntary muscle. The baby is legally defined as a live birth regardless of the period of gestation, if it breathes, or shows any other evidence of life, such as heart beat, pulsation of the umbilical cord, or definite movement of voluntary muscle. Because this fetus had a heart beat, this would be a live birth. You should file a birth certificate and death certificate.

PRESIDENT’S MESSAGE continued from p. 1
planning to attack the cap in the upcoming legislative session, so it is important that we stay informed and lobby our legislators to maintain it.

In the “old days” most malpractice cases were taken to court, and many decided in favor of the physician. These days most cases are settled before going to trial. Going to trial is an expensive gamble, and if there is a compelling plaintiff and a sympathetic jury, the award may be greater than the settlement offer. Malpractice carriers feel they can save money by settling. Many good doctors have their name in the National Practitioner Data Bank because it was too risky to go to trial. You can refuse to settle, but if your carrier refuses to back you, you are essentially on your own. If you loose, you can become personally liable for all awards.

Maryland ACEP will be working very closely with the Maryland Hospital Association this legislative session to maintain the malpractice caps and modify the statute of limitations for minors. As always, we need your support and input on this and other matters of importance to emergency physicians in Maryland. Visit our web site at www.mdacep.org and send us your comments and concerns.
As the holidays come and pass, it can only mean that a new legislative season is upon us. The 2003 session promises to be unlike any in recent memory. First, and foremost, about one-third of the General Assembly members are new. Second, there has been tremendous turnover in leadership, with a new Speaker of the House and several new chairs of key committees, and new chairs for all committees in the Senate. Third, we have a new governor who expressed support for us on many of our key issues during his campaign. However, given that he is from a different party than the majority of the General Assembly, legislative gridlock is almost inevitable. Fourth, the state is facing a staggering budget deficit that will occupy most of the legislators’ time and attention.

Your public policy committee spent the 2002 off-season using our PAC to support the campaigns of physician and physician-friendly legislators such as Delegate Dan Morhaim, Delegate Bobby Zirkin, Delegate Mary Ann Love, Delegate Mike Busch, Senator “Mac” Middleton, and Senator Andy Harris. We also supported the campaigns of newcomers who expressed support on our issues, such as Senator Jim Brochin, Delegate Herman Taylor, Delegate Susan McComas, and Delegate Neal Quinter. It is through this support, particularly in an election year, that we can ensure that our voice is heard in Annapolis. Yes, we were far outspent by the trial lawyers’ PAC, which is trying to remove Maryland’s tort liability caps, but this election demonstrated that well-placed contributions can achieve the desired result. Your continued support of the Emergency Medicine PAC when you renew your dues is critical in this effort.

The issue your Public Policy Committee will focus on this session is ED overcrowding, particularly the problem of placement of psychiatric patients. Governor Ehrlich made a specific campaign promise to address the needs of the mentally ill in our communities, and we intend to make sure he sticks to his promise. Another important issue that we will monitor closely is tort reform and the availability of reasonable liability insurance. As we have seen in other states, the first segments of the health care system to crumble under high liability insurance rates are obstetrics and emergency/trauma care. Other issues that we will monitor are Disaster Planning, AED funding, and HMO non-participating reimbursement.

With all these issues to address, we are going to need your help. First, volunteer to serve for a day as General Assembly Doctor, which will give you the opportunity to meet with your legislators and discuss the issues that are important to us. Second, join us for Doctor’s Day in Annapolis on Wed, February 12th. And finally, keep us informed on the issues that are important to you. Contact Claire Jefferson at the Chapter Office 410-727-2237 or mdacep@aol.com for more information on these activities.
Congratulations to our New Fellows!

Please join us in congratulating those Maryland ACEP members who became new and re-elected fellows for the year 2002.

New Fellows
Shobhit Arora, MD, FACEP
Dina Esterowitz, MD, FACEP
Angelo Falcone, MD, FACEP
Dawn Thornton, MD, FACEP
Shirin Trachiotis, MD, FACEP
James Trumble, MD, FACEP
Melissa Wu, MD, FACEP
Jennifer Yorke, DO, FACEP

Re-Elected Fellows
Donald Kohler, MD, FACEP
Lawrence Ouflero, MD, FACEP
Kevin Scruggs, MD, FACEP

Kudos to the Maryland Chapter on Their National Participation!

Maryland ACEP is proud of our members’ participation on committees on the national level. Those serving this year are:

Academic Affairs
Jeremy T. Cushman, MD
Alan Heins, MD
Amal Mattu, MD, FACEP

EMS
Robert R. Bass, MD, FACEP, Chair

Federal Government Affairs
Susan W. Owens, MD, FACEP

Emergency Medicine Practice
William P. Jaquis, MD, FACEP

Scientific Review
Robert E. Rosenthal, MD, FACEP

Public Health/Violence Prevention
Jon Mark Hirshon, MD, MPH, FACEP
Richard Rothman, MD, FACEP

Coding and Nomenclature Advisory
Michael A. Granovsky, MD

Public Relations
Leigh Vinocur, MD

Well-Being
Louise B. Andrew, MD, JD, FACEP

Reimbursement
David Hexter, MD, FACEP

Medical Legal
Louise B. Andrew, MD, JD, FACEP

Trauma Care and Injury Control
Robert R. Bass, MD, FACEP
Thanks to the following Maryland ACEP members who have contributed to EMPACt, the Maryland ACEP chapter PAC. Our PAC enables us to create good will, contribute to important political events and to express our thanks to elected officials who stood up for us in Annapolis. We realize that, as physicians, we receive many requests for contributions, and we appreciate your contribution to EMPACt.

As of August 1, 2002, the following members have supported our PAC:

Vincent Bocchino, MD, FACEP  William Jaquis, MD, FACEP  Steven Remsen, MD, FACEP
Michael Bolognese, MD  Scott Kelso, MD  Ronald Ross, MD
Linda DeFeo, MD, JD, FACEP  Ronald Kinsey, MD  David Srour, MD, FACEP
Angelo Falcone, MD  George Long, MD, FACEP  Michael Stang, MD, FACEP
David Frazier, MD, FACEP  Anil Mahajan, MD, FACEP  Edward Thompson, MD
Giorgio Galetto, MD  Elizabeth Maxwell-Schmidt, MD  Joseph Twannmoh, MD, FACEP
Kenneth Gummerson, MD, FACEP  John Molesworth, DO  William Watson, MD, FACEP
Edna Hill, MD, FACEP  David Mooradian, MD  Jonathan Wenk, MD
Hugh Hill, III, MD, JD, FACEP  Weneilis Navarro, MD  Robert Yacynych, MD, FACEP
Timothy Holland, MD  Julian Orenstein, MD, FACEP  John Wogan, MD, FACEP

Calendar of Events

January 24, 2003
Board of Directors
Med Chi, 2nd Floor Board Room

March 29, 2003
Oral Board Preparation Course
BWI Sheraton International Hotel

April 25, 2003
Maryland ACEP Annual Educational Conference
BWI Sheraton International Hotel

April 25, 2003, noon
Board of Directors
BWI Sheraton International Hotel
In conjunction with the Annual Educational Conference

July 25, 2003
Board of Directors
Med Chi, 2nd Floor Board Room

Congratulations!

To Jeremy T. Cushman, MD, of the University of Maryland, Baltimore, who was elected president-elect/treasurer of EMRA. Jeremy is also representing the residents at University of Maryland on Maryland ACEP’s Board of Directors.

To Emergency Medicine Medical Student Brett Dee Nelson at the Johns Hopkins University School of Medicine on receiving a research grant from National ACEP’s Emergency Medicine Foundation and the Society for Academic Emergency Medicine. The project title is “Social Determinants of Emergency Medical Care Utilization in a Post-Conflict Setting.”

To Emergency Medicine Medical Student Amy Schuster at the University of Maryland at Baltimore on receiving a research grant from National ACEP’s Emergency Medicine Foundation and the Society for Academic Emergency Medicine. The project title is “Molecular Mechanisms of Cerebral Ischemic Brain Injury.”
Welcome To New Members

Please join us in extending a warm welcome to the following individuals who have recently joined ACEP and the Maryland Chapter. We encourage you to attend Committee and Board meetings. Get Involved!

New Members

Cory Bergey, DO
Michelle Bisutti, MD
Scott Brannan, MD
Amy Burford, MD
Rose Chasm, MD
Chythia Chiu-Pinhero, MD
Tanveer Gaibi, MD
Andrew Garff, MD
David Hager, MD
Jonathan Hansen, MD
Laurie Herrera, MD
Adina Israel, MD
Margarita Jovel, MD
Shira Kansas, MD
Kamilah Kelly, MD
Belwon Martin, MD
Joseph Martinez, MD
Douglas Mayo, MD
Morgen McCullough, MD
Andrew Meltzer, MD
Jay Menaker, MD
Alfred Mingo, MD
Nicole Maichajian, MD
Richard Nguyen, MD
Jack Perkins, MD
Amber Reiss-Holt, MD
Brian Rudick, MD
Michael Semchynshyn, DO
Daniel Sessions, MD
Taha Shaikh, MD
Sharon Swencki, MD
Alice Tang, DO
Naomi Teufel, MD
Marney Treese, MD
Stephen Wegner, MD
Michael Winters, MD
Laura You, MD

Transfer Members

Gregory Bledsoe, MD
Henry Chu, MD
Richard Ferraro, MD
Chad Hansen, MD
Terri Holmes, MD
Michelle Huston, MD
Christopher Jillson, MD
Kerith Joseph, MD
Douglas McPhee, MD
Tsuoshi Mitaral, MD
Anthony Moracco, MD
Clark Morres, MD, FACEP
David Posner, MD
Purvi Shah, MD
Robert Slaney, MD, FACEP
Sara Sutherland, MD, FACEP
David Vitberg, MD
Amit Wadhwa, MD
Leah Wendell, MD

23 Members moved out of chapter
Maryland ACEP Annual Educational Conference
Friday, April 25, 2003

Look for the program brochure to be mail shortly.