



# EM Malpractice in Minnesota

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Eric Funk, MD





From rumors to facts...

A close-up photograph of a campfire with several marshmallows on sticks being roasted. The fire is bright orange and yellow, with flames rising from a bed of dark, charred wood. The marshmallows are white and slightly puffed. The background is dark and out of focus, showing more of the fire and the surrounding environment. The text "Playing with Fire" is overlaid in the center in a white, sans-serif font.

Playing with Fire

A photograph of the Minnesota State Capitol building at dusk. The building is illuminated with warm lights, and its large, ornate dome is the central focus. The sky is a deep blue. In the foreground, there are trees, streetlights, and a few cars parked on the street.

# Minnesota Supreme Court Case

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# 38-year-old man with headache

Presents at 4:40am with multiple weeks of symptoms

Associated symptoms:

- Shortness of breath
- Diaphoresis
- Dizziness
- Bulging Eyes
- Balance Problems

Just got back from Russia, where he had dental work done

# Workup

EKG: reportedly normal

CBC/CMP: normal

CT head:

Clinical History: Headache

Technique: Noncontrast axial CT images are obtained of the brain.

Comparison: None.

Findings: The brain parenchyma, sulci and ventricles of the brain are unremarkable for age. No intracranial mass, mass effect, midline shift, or hemorrhage is seen. Nothing specific for acute infarction.

Minimal diffuse mucosal thickening involving the maxillary sinuses and a few ethmoid air cells. No acute air-fluid levels. Osseous structures otherwise unremarkable.

Impression:

1. No evidence for acute intracranial hemorrhage, mass effect or acute ischemic event.
2. Minimal mucosal thickening involving the maxillary sinuses and a few ethmoid air cells. No acute air-fluid levels.

Benadryl, Compazine, fluids – improved

Referred to neurology

Discharged

# Bounceback

Wife finds him unresponsive a few hours later

Brought back to ED

Seizure-like activity / convulsions

# Workup

CT ANGIO HEAD performed 1159 - 1201

Clinical History: Seizure.

Technique: Contrast enhanced CT was performed of the major intracranial arteries utilizing bolus arterial phase with multiplanar/reconstructed data sets. 3-D maximum intensity projections (MIPS) were obtained. 3-D rendering was performed on an independent workstation.

Comparison: None.

Findings: Occlusion of the distal left posterior cerebral artery is present. Moderate stenosis of the proximal left PCA noted. Moderate to severe stenosis of the proximal right PCA is present. Right PCA distal to this appears unremarkable. Mild to moderate stenosis distal right vertebral artery distal to the PICA and right vertebral artery at the vertebrobasilar junction is noted. Distal internal carotid arteries and anterior and middle cerebral arteries and branches appear within normal.

Negative evidence for intracranial aneurysm.

Impression:

1. Occlusion of distal left posterior cerebral artery corresponding with known involving cortical swelling.
2. Multifocal stenoses involving the posterior circulation as above.
3. Constellation of findings is concerning for vasculitis involving the posterior circulation. Other forms of vasculopathy such as unusual atherosclerotic disease are also possible.
4. Findings discussed with Dr. M [REDACTED] in the emergency department on 2/9/2016 12:58 PM.

# Workup

Technique: Multiplanar multisequence MRI performed. Exam performed without and with intravenous gadolinium.

Comparison: CT brain February 9, 2016 at 1148 hours.

Findings: Highly restricted diffusion noted in the left thalamus, left occipital lobe, posteromedial left temporal lobe, left paramedian midbrain and pons and bilateral cerebellar hemispheres. Findings compatible with multiple acute posterior circulation infarcts. Mild localized mass effect. No midline shift. Negative evidence for hemorrhagic transformation, mass lesion, shift or hydrocephalus. Basal cisterns are intact. Normal orbits and sella. Right cerebral hemisphere unremarkable.

Postcontrast images demonstrate minimal linear enhancement involving the left occipital infarct suggesting that this may be entering an early subacute stage.

Cerebellar, brainstem and thalamic infarcts were not clearly evident on the comparison CT.

Impression: Acute to subacute posterior circulation infarcts without hemorrhagic transformation or significant mass effect.

Findings discussed with Dr. H [REDACTED] on 2/9/2016 3:35 PM

Procedure(s):

1. Cerebral / cervical angiography: right vertebral artery, left subclavian artery selective injections
2. AngioSeal hemostatic device: right common femoral artery

Pre-operative diagnosis (indication): Posterior circulation acute ischemic stroke, possible thrombectomy candidate

Post-operative diagnosis: Same, thrombectomy deferred

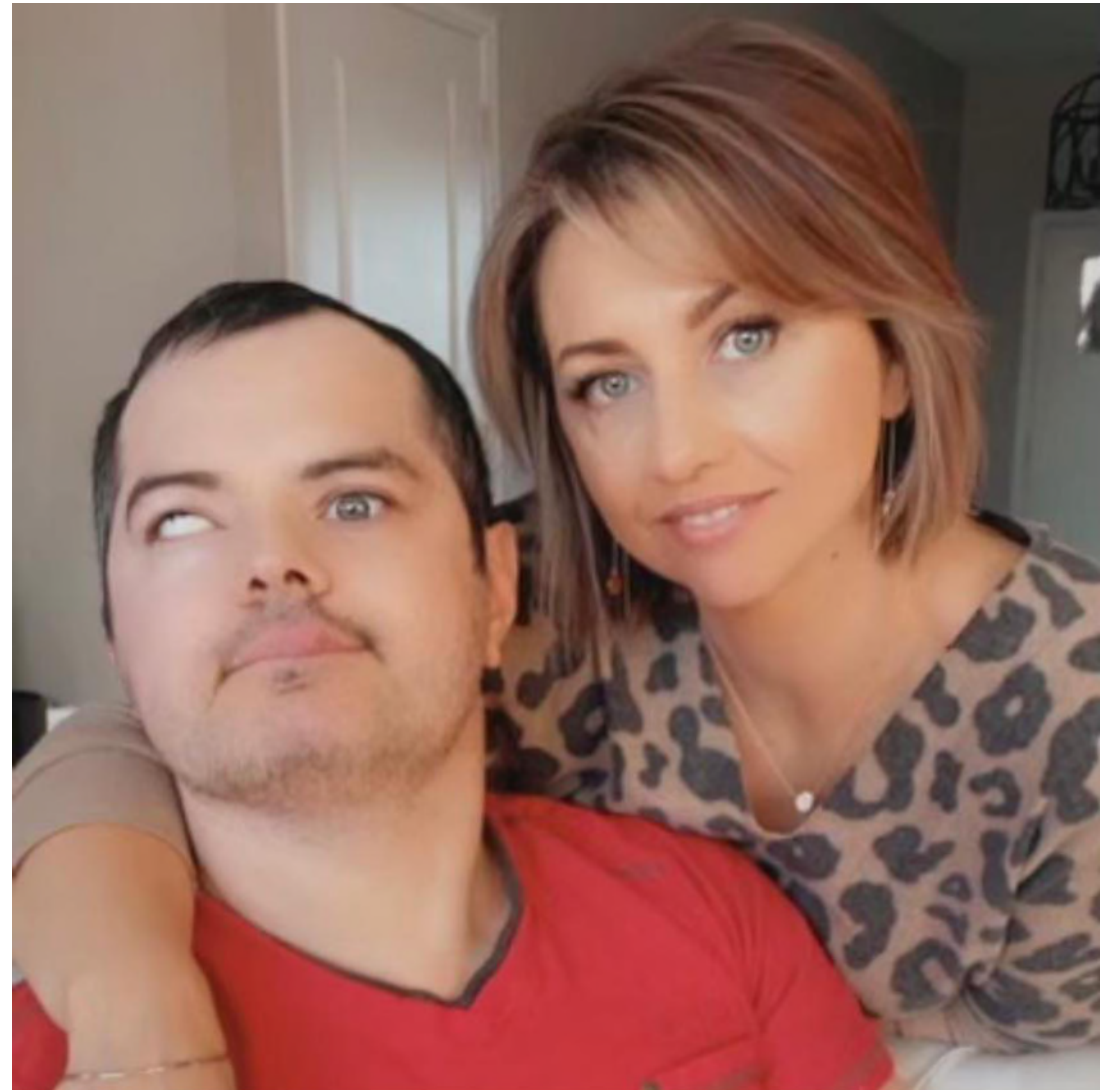
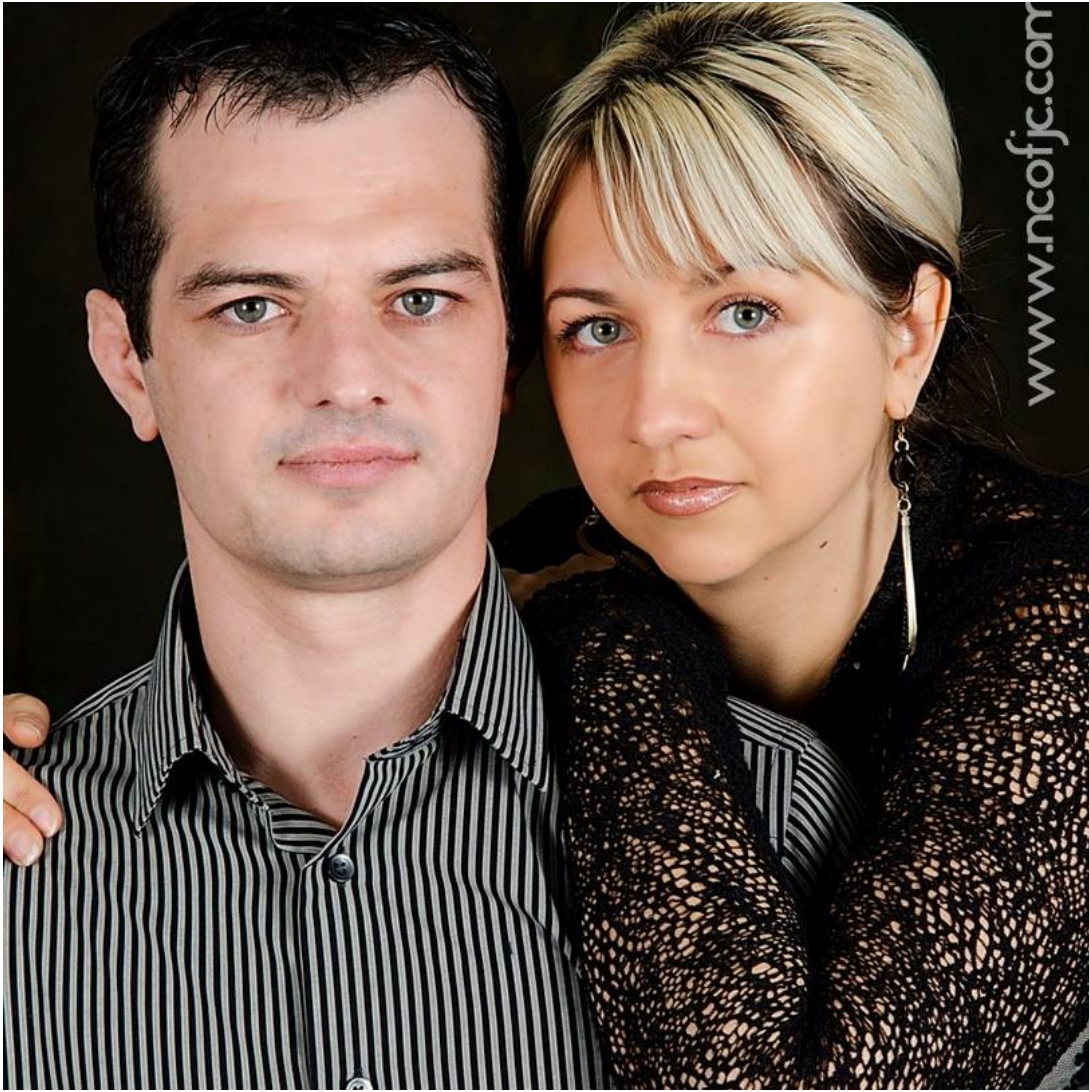
Findings: There is a flow-limiting dissection of the proximal left vertebral artery associated with thrombus. The smaller right vertebral artery is the predominant supply to the posterior circulation.

The left posterior cerebral artery is occluded with thrombus. Partially occlusive thrombus at the top of the basilar artery does allow filling of the right posterior cerebral artery.

Of note, the distal right vertebral artery is somewhat dysplastic, possibly related to a previous healed dissection.

Impression:

1. Top of the basilar thrombus that occludes the left PCA, only partially occludes the origin of the right PCA.
2. Flow-limiting, proximal left vertebral dissection associated with thrombus; thrombectomy deferred.



# Lawsuit

## Defendants:

- Both ER doctors
- Independent ED staffing group
- Radiology group
- Hospital

# Vicarious Liability

## Working Definition:

a legal doctrine that holds one party responsible for the negligence or misconduct of another, even if the first party was not directly involved in the incident.

Historically only applied to hospital employees, not contractors.

# Hospital Dismissed

“In Minnesota, a hospital can only be held vicariously liable for a physician’s acts if the physician is an employee of the hospital.” *McElwain v. Van Beek*, 447 N.W.2d 442, 446 (Minn. 1989) (citing *Moeller v. Hauser*, 54 N.W.2d 639, 645–46 (Minn. 1952)). Plaintiffs’ Amended Complaint acknowledges that the doctors who treated Mr. ██████ were not ██████ employees, and instead were employees of outside organizations which provided emergency services to Defendant ██████ on a contractual basis. Plaintiff’s Amended Complaint attempts to allege that Defendant ██████ is vicariously liable for the actions of physicians who are not employees of Defendant ██████, which is expressly precluded by *McElwain*. See *id.*; *Kramer v. St. Cloud Hosp.*,

# Appeals Court

Applying *McElwain* here, we determine that [REDACTED] is not vicariously liable for the acts of the emergency-room physicians as a matter of law. *See* 447 N.W.2d at 446 (holding independent contractor-physician with staffing privileges at hospital is not an employee of hospital). The record establishes that Drs. H [REDACTED] and M [REDACTED] were not [REDACTED] employees, but were instead employed by the Emergency Physicians [REDACTED]. Because the uncontested evidence demonstrates that the physicians were not employed by the hospitals or by [REDACTED], [REDACTED] is “relieved of liability.” *Id.*

# Supreme Court

## SYLLABUS

1. A hospital may be vicariously liable on a theory of apparent authority for the professional negligence of an independent contractor.

2. A plaintiff states a vicarious liability claim against a hospital for the professional negligence of an independent contractor in the hospital's emergency room based on a theory of apparent authority if (1) the hospital held itself out as a provider of emergency medical care; and (2) the patient looked to the hospital, rather than a specific doctor, for care and relied on the hospital to select the personnel to provide services.

Reversed and remanded.

# Apparent Authority: Implications

- Hospital Contracts
- Co-defendants



# Hospital Settles

1. On June 13, 2018, Plaintiffs commenced suit against [REDACTED]. (See Admission of Service attached hereto as Exhibit B.)
2. Plaintiffs' Complaint alleged that [REDACTED] was vicariously liable for the allegedly negligent conduct of Defendants [REDACTED] H [REDACTED], M.D. and [REDACTED] M [REDACTED], M.D. based on a theory of apparent authority. (See Complaint, Index #11.)
3. Plaintiffs have agreed to dismiss their claims against [REDACTED] (hereinafter the "Apparent Authority Claim") without prejudice.
4. Plaintiffs intend to continue litigating their claims in this matter against Defendants Emergency Physicians [REDACTED], [REDACTED] H [REDACTED], M.D., and [REDACTED] M [REDACTED], M.D. (hereinafter the "remaining Defendants").
5. [REDACTED] has agreed that Plaintiffs may re-assert their Apparent Authority Claim against [REDACTED] if Plaintiffs obtain a jury verdict and subsequent judgment in their favor against the remaining Defendants and are not able to collect the total amount of the judgment from the remaining Defendants or their liability insurers.

# Key Obstacles

## Multiple symptoms

- Headache
- Diaphoresis
- Dizziness
- Bulging Eyes
- Balance problems
- Shortness of breath

## International Travel

## Dental work

## Time of presentation

# Unique topics

## Headache in stroke

~70% of dissection cases<sup>1</sup>

posterior circulation stroke<sup>2</sup>

## Lack of stroke activations

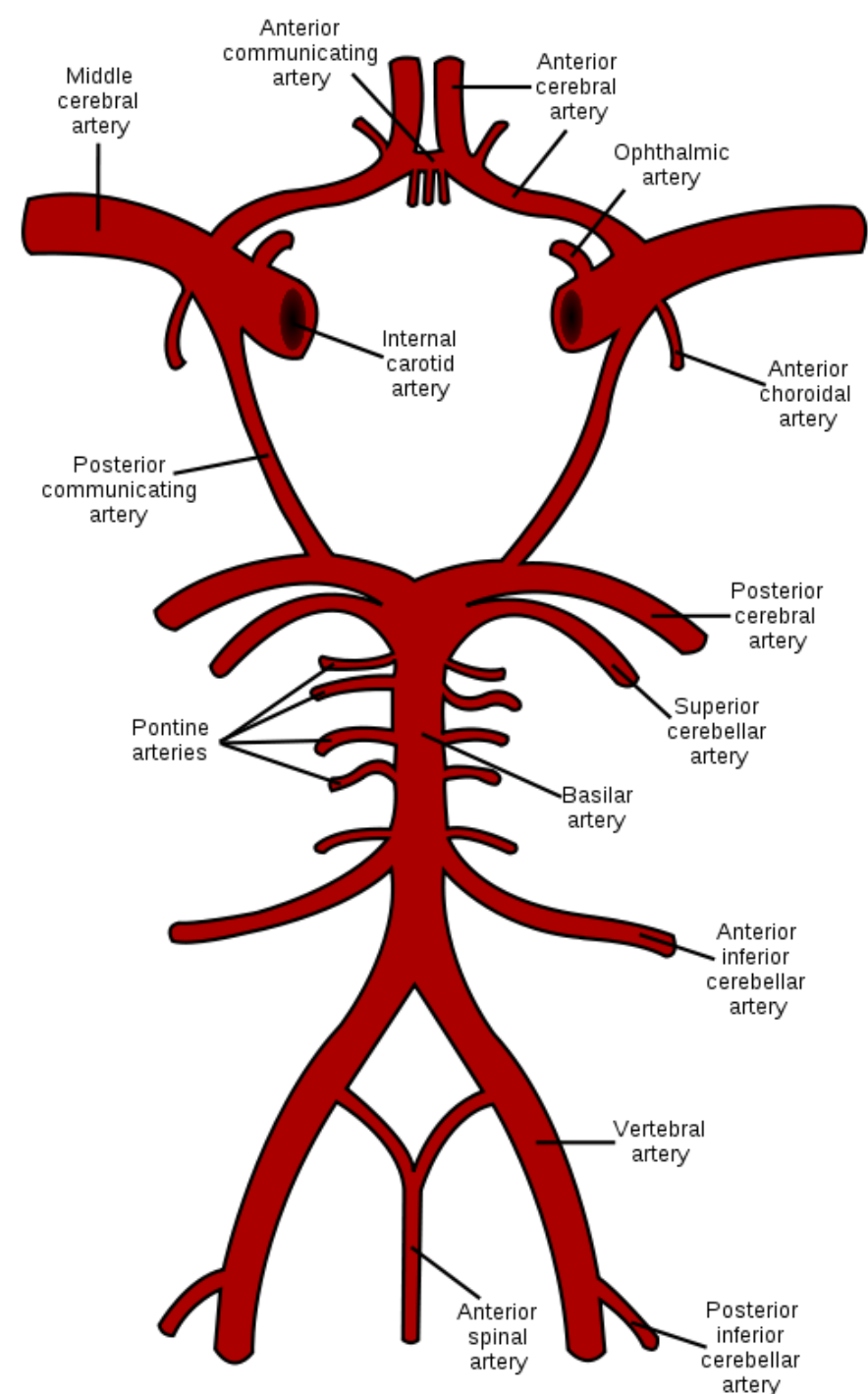
longer symptom-to-contact times<sup>3</sup>

posterior circulation<sup>3</sup>

## Convulsions in Basilar Occlusion

convulsive movements<sup>4</sup>

“seizures”<sup>5</sup>



# References

1. Vidale S. Headache in cervicocerebral artery dissection. *Neurol Sci.* 2020 Dec;41(Suppl 2):395-399. doi: 10.1007/s10072-020-04651-8. PMID: 32852688.
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3. Girona San Miguel A, et al., on behalf of the Catalan Stroke Code and Reperfusion Consortium (Cat-SCR). Stroke Code Missed Activations by Emergency Medical Services: Identifying Gaps and Opportunities for Improvement. *Prehosp Emerg Care.* 2025 Dec 12:1-6. doi: 10.1080/10903127.2025.2592878. Epub ahead of print. PMID: 41324970.
4. Zhang D, Chen Y, Hao Y, Hu X, He X. Acute Basilar Artery Occlusion Presenting With Convulsive Movements: A Systematic Review. *Front Neurol.* 2022 Jan 7;12:803618. doi: 10.3389/fneur.2021.803618. PMID: 35069431; PMCID: PMC8777068.
5. Otsuji R, Uno J, Motoie R, Karashima S, Ren N, Nagaoka S, Maeda K, Ikai Y, Gi H. Basilar Artery Occlusion with "Seizures" as a Presenting Symptom: Three Cases Treated Using Mechanical Thrombectomy. *World Neurosurg.* 2018 Sep;117:32-39. doi: 10.1016/j.wneu.2018.05.227. Epub 2018 Jun 7. PMID: 29886293.



Questions?