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Health Care Reform: Should It Grant Physicians Immunity for EMTALA-Mandated Services?

By Robert A. Bitterman, MD, JD, FACEP, and Michelle Bitterman Fish, JD

The federal government, through the Emergency Medical Treatment and Active Labor Act (EMTALA), as well as some states such as California and Florida, mandates hospitals and physicians to provide medical services to anyone presenting to the hospital's emergency department (ED). Why shouldn't governmental liability protections, such as immunity and/or damage limitations, apply to providers of emergency services?

Two of the stated goals of the congressional and administration's health care reform agendas are access to health care, particularly for the uninsured, and lower health care costs. Yet glaringly absent is consideration, let alone a plan, for medical liability reform, which has a proven track record of improving access and lowering costs.

Texas Tort Reform

Texas's story is the perfect example. In 2003, its health care situation was bleak. Every year, 25% of the state's physicians were sued at least once.[1,2] Malpractice premiums were increasing 25% to 50% per year—if insurance coverage was available, since all but four of the nearly 40 prior liability carriers had abandoned the state.[2] Doctors were discontinuing services perceived to be high-risk, or leaving the state altogether. Texas ranked 48th out of 50 states in the number of physicians per capita.[2] Sixty percent of the counties in Texas had no obstetrician, and more than half didn't have a pediatrician. There were not enough neurosurgeons in San Antonio to place even one neurosurgeon on call for the city 24 hours a day year-round, and south of Corpus Christi, there were no neurosurgeons at all.[1,2]

Fed up with the status quo, the Texas Legislature passed a series of tort reform packages, culminating in 2003 with a law that limited a plaintiff's non-economic damages to $250,000 from doctors, and an additional $250,000 from each of up to two health care facilities.[3,4] The Texas reform limited non-economic damages similar to California's successful tort law and did not cap com-

pensatory economic awards whatsoever.[3]

Furthermore, the legislature recognized the unique role and circumstances of its EDs by imposing a higher burden of proof to sue emergency physicians, on-call physicians, and hospitals providing emergency care — "willful and wanton neglect" instead of ordinary negligence.[3] It sought to encourage people to work in emergency care and understood the exigencies of making critical decisions in the ED, often without adequate medical histories.

It required a constitutional amendment to give the Legislature the authority to cap non-economic damages and affirm the enacted medical liability reforms.[5] The amendment, known as Proposition 12, was a source of a contentious debate between the plaintiffs' bar and groups who believed the changes would increase access to health care. The voters of Texas approved the amendment by a substantial margin.[1,2]

The turnaround in Texas's health care climate has been nothing less than profound.

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Contributing Editors: Robert Bitterman, MD, JD, FACEP; and Stacey Kusterbeck.
Director of Marketing: Schandale Kornegay

Questions & Comments

Please contact **Allison Weaver,** Managing Editor, at allison.weaver@ahcmedia.com.

The number of lawsuits dropped dramatically—nearly 50% within two years in the San Antonio, Fort Worth, Dallas, and Houston areas. The state's largest medical liability carrier, Texas Medical Liability Trust, also reported a 50% reduction in lawsuit filings.[2] As a consequence, every major medical malpractice insurer in Texas cut their rates by double-digits. Texas physicians currently pay premiums 25% lower than they did before the passage of tort reform, according to the Texas Medical Association and state insurance department data.[1,6,7] There are also more than 30 new insurers in the state, competing with the lone foursome that existed in 2003.[1]

Since 2003, Texas has licensed more than 14,500 new doctors, with each year setting a new record for the number of license applications filed.[1,8] In fact, at one point the Texas Board of Medical Examiners was so overwhelmed with new physician applications that it requested and was granted a special appropriation from the legislature to hire more personnel.[9] The state experienced nearly a 10% increase in the influx of specialists such as OB/GYNs, neurosurgeons, and orthopedic surgeons between May 2003 and May 2008, often in rural, previously underserved areas markedly improving access to care. Many areas where patients had no access to care now enjoy fully staffed facilities.[1,6,8]

The medical liability reforms, particularly the limitation on non-economic damages, are credited with creating more than 223,000 new jobs in Texas.[10] It is also believed that the enactment of tort reform of 2003 kept open approximately 30,000 nursing home beds in Texas, which provide continuing services to the elderly.[1,2]

The Texas experience impressively illustrates the advantageous effects of medical liability reform measures. Texas improved access and lowered costs through a combination of procedural reforms, changes in the standards of liability and burden of proof, and caps on non-economic damages.[3]

Other states have taken notice. Arizona, for example, revised its laws this year to elevate the burden of proof required to recover damages from malpractice to a "clear and convincing" standard (instead of the usual "preponderance of the evidence standard") for any health professional, including emergency physicians and on-call physicians, or hospital acting in compliance with EMTALA.[11]

Georgia limited emergency-room-based malpractice claims in three ways. First, the level of culpability necessary for liability was increased from negligence to gross negligence. Second, the plaintiff's burden of proof was also increased to the clear

and convincing evidence standard. Third, the statute requires the judge to provide certain beneficial jury instructions in ED cases.[12] Georgia's new rules, though, are less comprehensive in the sense that they are not triggered unless the patient has a real emergency condition. Thus, they would not apply to all patients who receive medical care in the emergency room.[13]

In Ohio, a bill was recently introduced that would grant qualified immunity to any physician who provides emergency medical services in compliance with EMTALA if the physician's act or omission does not constitute "willful or wanton misconduct."[14] Interestingly, the Ohio bill does not appear to protect midlevel providers acting in compliance with EMTALA,[15] since the language of the bill protects a *physician* who provides emergency services.[16]

Though it gets much less attention than the noneconomic damages cap, Texas also modified its sovereign immunity law to further protect ED and on-call physicians providing emergency services. Physicians will be considered "public servants" when working for state and county hospitals, and their liability limited to a maximum of $100,000 with the governmental entity responsible for any excess award. A public servant includes "a licensed physician who provides emergency or post-emergency stabilization services to patients in a hospital owned or operated by a unit of local government."[17]

Sovereign immunity is one reform proposal infrequently considered, but it has enormous potential to help fund health care reform.

What Is Sovereign Immunity?

Sovereign immunity is defined as "a government's immunity from being sued in its own courts without its consent."[18] Its origin can be traced back to early England, based upon the notion that "the King can do no wrong."[19] The concept is grounded in the belief that public policy considerations dictate that a group of persons "require special protection for the person, activity or entity in question"—ostensibly for the greater benefit of society, even if somewhat at the expense of an injured party.[20]

A classic example of federal sovereign immunity is the recent case of *Hoffman v. United States*, decided by a federal district court in Virginia.[21]

A pregnant Ms. Hoffman presented with abdominal pain to the ED of Naval Medical Center in Portsmouth, VA, where she was triaged and moved to the labor and delivery unit for evaluation. She was released (plaintiffs argue prematurely), and several hours later delivered her baby at the Chesapeake General Hospital. The baby died from necrotizing entercolitis a month later. Ms. Hoffman sued the Naval Medical Center for medical malpractice and also brought an EMTALA claim alleging failure to screen and stabilize her before discharge.

The defendant in the case was the United States, because the Naval Medical Center was owned and operated by the federal government. However, the United States filed a motion for summary judgment claiming it could not be sued under EMTALA on account of its sovereign immunity, which it did not waive when it enacted EMTALA.[21]

According to U.S. Supreme Court precedent, "a waiver of sovereign immunity must be 'unequivocally expressed' in the statutory text."[22] The court found no such "expressed waiver" in EMTALA's statutory language.[21] Furthermore, nowhere in the civil enforcement section of EMTALA (or anywhere else in the statute) does it mention the United States government or any hospital owned by the government. Therefore, the court held that the US Naval hospital could not be sued under EMTALA. (The plaintiffs still had a remedy under the Federal Torts Claims Act for the hospital's alleged negligence.)

The courts have consistently held that government-run hospitals can not be liable to private plaintiffs for violations of EMTALA.[23] Thus, while the government passed EMTALA to ensure access to emergency care, it exempted itself from compliance and liability under the law to avoid draining the public purse.

The Case of Martinez v. Maruszczak[24]

The states also have sovereign immunity. The Eleventh Amendment to the U.S. Constitution grants sovereign immunity to the states, such that the states are not subject to liability under federal laws unless they expressly waive their immunity.[25,26] The Nevada Supreme Court's recent opinion in *Martinez v. Maruszczak* illustrates the benefits the doctrine of sovereign immunity can bring to health care reform.[24]

This malpractice case arose out of a death from accidental injuries Mr. Maruszczak sustained while being treated by Dr. Martinez at the University Medical Center in Las Vegas, NV. One issue before the court was whether Dr. Martinez was protected by Nevada's sovereign immunity statute from liability relating to his treatment of Mr. Maruszczak.[24] Nevada caps the liability for tort claims at $50,000 per claim, if the physician is a "public employee" of the state.[27,28]

Dr. Martinez worked for the University of Nevada School of Medicine and was acting within the scope of his employment during the alleged act of medical

malpractice, so the court deemed him a "public employee" and therefore ostensibly protected by the statute's $50,000 damage limitation.[24]

The court then dismissed the plaintiff's claim that the sovereign immunity damages cap violated the due process and equal protection guarantees under the Nevada and United States Constitutions.[29-31] It held that the plaintiffs argument failed to differentiate between the *right to recover* and the *amount of recovery*, and that the recovery amount is always uncertain and subject to remarkable variations among claimants.[24]

Moreover, the court enunciated the public policy behind Nevada's statutory qualified immunity.[24] First, protecting the state treasury was a legitimate state interest, thus providing a rational basis for capping damages at $50,000 for allegedly negligent acts committed within the scope of state employment. Second, capped damages also advanced a legitimate state interest in encouraging qualified professionals to accept state employment to serve the people of Nevada.[24,32] The court noted that operation of a public hospital is a core government function designed to ensure broad availability of access to medical care. It also recognized "the fact that state-employed physicians may treat private paying patients does not undermine the need for public hospitals to generate income to offset the costs of providing large-scale indigent medical care."[24]

It rejected the notion that state-employed physicians with capped liability wouldn't be incentivized to exercise appropriate care in the treatment of their patients, particularly since incidents of malpractice affect employability, costs of insurance premiums, and subject physicians to national data bank reporting.[24]

Conclusion

Why shouldn't governmental liability protections, such as immunity and/or damage limitations, apply to providers of EMTALA mandated emergency services? Isn't emergency care an essential community service, exactly like police and fire protection? Don't we need neurosurgeons on call to put out "fires" in an emergency? Don't public policy considerations dictate that safety-net providers—such as hospital EDs, emergency physicians, trauma physicians, on-call physicians, and EMS systems—that care for patients on an emergency basis under government mandates "require special protection for the greater benefit of society"?

The cost of litigation is borne by all Americans in some capacity, either through increased health care premiums, drug prices, vaccine costs, increased deductibles, increased co-pays, lower wages, or loss of health insurance coverage. It extracts precious dollars out of the health care system that would otherwise be available to actually provide health care services. In a country utterly desperate for money to fund its health care initiatives how can we not enact medical liability reform on a national level?

The states have recognized and are living proof that medical liability reform improves access to care and lowers the overall cost of health care.[33] States with effective tort reforms also have on average 12% more physicians per capita than states without such reforms.[34]

The issue needs to be recast from "hospitals and physicians vs. plaintiff attorneys and potential large damage awards" into what's in the best interest of society as a whole. From a public policy perspective, control of litigation costs, such as through non-economic damage caps or sovereign immunity, benefits society by assuring access to available emergency services at reasonable prices.

The federal government (or alternatively the states) should designate safety net providers as "public servants" for purposes of liability when providing services under EMTALA or state EMTALA-like laws, and grant them sovereign immunity, at least to some degree.

Congress, indeed, must act. Access to health care is a public policy issue that requires a political solution. Access to health care, accountability of health care providers, and appropriate utilization of limited resources are immense issues for our society, subject to and solvable only on a political level. But the solutions should be driven by public policy; i.e., what is in the best interests of the health and well-being of our patients and the interests of the country, as opposed to the interests of a single individual (aggrieved plaintiff) or particular special interest group (e.g., doctors, lawyers, insurers, hospitals, legislators).

One question our representatives conspicuously did not ask the folks at those contentious town hall meetings was which they would prefer—access to health care or potential mega-jury awards for malpractice injuries? The answer would have been an overwhelming and resounding request for access to available, affordable, quality health care.

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What Are the Biggest Liability Risks Involving ED Handoffs?

The electrocardiogram (EKG) and x-ray of a chest pain patient in his mid-50s were both normal when examined by the treating ED physician. However, the physician's shift ended before the patient's lab results were back. Based on the test results that were back, the oncoming ED physician discharged the patient as "chest pain, non-cardiac." Several hours later, the lab results came back with critical values.

"At that time, the patient was just arriving at another hospital and was pronounced dead from a heart attack," says **Stephen A. Frew, JD**, vice president and risk consultant with Johnson Insurance Services, a Madison, WI-based company specializing in risk management for health care professionals. Both the discharging ED physician and the original hospital were cited for violations of the Emergency Medical Treatment and Labor Act (EMTALA), for discharging the patient without completing necessary testing and inadequate medical screening.

In another "handoff" lawsuit, a 38-year-old man with extreme radiating pain in his back was evaluated by an ED physician who found no neurological involvement and diagnosed back pain. The patient was discharged with pain medications and instructions to apply ice. Before he left the hospital, the plaintiff screamed out in pain, saying that he could no longer feel his legs and had lost bladder control.

The ED nurses alerted the ED physician, who had

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SPECIAL REPORT

Medicolegal Aspects of Informed Consent in the ED

By Randall Best, MD, JD, *Assistant Professor, Division of Emergency Medicine, Department of Surgery, Duke University School of Medicine, Durham, NC.*

Anyone recently considering an elective medical procedure knows that physicians' efforts in obtaining proper informed consent have become increasingly elaborate. The use of detailed educational materials and videos are common. However, in the emergency department (ED) there has not been a similar trend. Usually, such elaborate efforts are not practical due to the urgency of the treatment or procedure under consideration. Even so, with the current emphasis on patient autonomy and satisfaction, it is likely that the informed consent process in the ED will receive increased scrutiny along with corresponding heightened medicolegal concerns.

A better understanding of the legal issues involved in obtaining informed consent can serve as a starting point to enable emergency physicians to consistently meet their medical, ethical, and legal obligations. Under American tort law, the failure to obtain informed consent in and of itself does not provide a proper cause of action. Rather, that failure may serve as a theory under which a recognized tort claim such as battery or negligence may be pursued.[1] Battery is defined as an intentional and offensive touching of another without lawful justification.[2] Medical malpractice, a doctor's failure to exercise the degree of care and skill that a physician of the same medical specialty would use under similar circumstances, is a type of negligence.[3] The elements of a malpractice negligence action are as follows:

1. Duty;
2. Breach of that duty;
3. Harm to the patient; and
4. Causation that the breach of duty caused the harm.[4]

Thus, a medical malpractice claim for failure to obtain informed consent would allege that the physician defendant breached the duty to obtain informed consent and that breach constitutes a proximate cause of the harm suffered by the patient plaintiff.

Likely unknown by most physicians, the area of informed consent has an extensive legal history. The seminal case requiring a physician to obtain his patient's "informed consent" is *Salgo v. Leland Stanford, Jr. University Board of Trustees,* where the court held that a physician "violates his duty to his patient and subjects himself to liability if he withholds any facts which are necessary to form the basis of an intelligent consent by the patient to the proposed treatment."[5] Jurisdictions employ one of three separate approaches to determine whether a physician has properly provided informed consent.[6] Historically, the majority employed the physician-based standard set forth in *Fain v. Smith* that the "doctor's duty to get the informed consent of the patient must be measured by a professional medical standard."[7] A second, increasingly common approach is the "reasonable patient" or "objective standard" as held in the landmark case of *Canterbury v. Spence* that makes the reasonable patient the measure of the scope of disclosure by requiring a physician to disclose information a reasonable patient would desire.[8] The final approach, termed the subjective standard, espoused in *Scott v. Bradford*, requires a doctor to disclose information that would be material to decision making for the particular patient in question thus preserving the individual patient's rights of self-determination.[9] That approach has been adopted in only a few jurisdictions. Courts more commonly agree with the reasoning of *Canterbury* that the reasonable patient standard is fairer for physicians as it relieves the doctor from the need to anticipate any unusual peculiarities of a particular patient as well as avoiding placing the "physician in jeopardy of the patient's hindsight and bitterness" if a lawsuit develops.[10]

Increasingly, states have codified common law judicial decisions into statutory law. For example, North Carolina has combined the requirements of the physician based and reasonable patient standards under statutory law as follows:[11]

Informed consent to health care treatment or procedure.

(a) No recovery shall be allowed against any health care provider upon the grounds that the health care treatment was rendered without the informed consent of the patient or other person authorized to give consent for the patient where:

(1) The action of the health care provider in obtaining the consent of the patient or other person authorized to give consent for the patient was in accordance with the standards of practice among members of the same health care profession with similar training and experience situated in the same or similar communities; and

(2) A reasonable person, from the information provided by the health care provider under the circumstances, would have a general understanding of the procedures or treatments and of the usual and most frequent risks and hazards inherent in the proposed procedures or treatments which are recognized and followed by other health care providers engaged in the same field of practice in the same or similar communities; or

(3) A reasonable person, under all the surrounding circumstances, would have undergone such treatment or procedure had he been advised by the health care provider in accordance with the provisions of subdivisions (1) and (2) of this subsection.

In interpreting this statute, North Carolina courts have concluded that negligence actions based upon a health care provider's failure to obtain informed consent require testimony of a qualified expert to establish the requisite standard of care for providing informed consent.[12]

Clark v. Perry provides illustration of the proper application of this statute.[13] Clark, a practicing Jehovah's Witness, developed complications of AIDS and was admitted to the hospital by his personal physician, Dr. Jacinto. Dr. Jacinto was aware of Clark's religious beliefs and his desire not to receive blood products. Clark's medical chart contained this information, as well. During the hospitalization, Dr. Jacinto consulted Dr. Perry, a pulmonologist, who subsequently performed a bronchoscopy. Upon being notified of a significant drop in hemoglobin after the procedure, Dr. Perry ordered a blood transfusion on Clark. Clark was not awake during the transfusion of the first unit. He and his wife later became aware that blood had been transfused when a nurse prepared to administer the second unit. Clark's wife later testified that they both became extremely upset and remained so until his death a short time later. Other witnesses offered conflicting testimony as to the degree that Clark and his wife suffered emotional distress.

Ms. Clark filed suit against Dr. Jacinto, Dr. Perry, and the hospital. Among the allegations in her complaints included a claim of negligence for failure to obtain informed consent for the blood transfusion. Subsequently, she dismissed Dr. Jacinto from the lawsuit and the case proceeded against the remaining defendants. At the close of plaintiff's evidence, the remaining defendants moved for a directed verdict. On the issue of whether the defendants were negligent in failing to obtain informed consent, the trial court granted the motion for a directed verdict in favor of the defendants citing the plaintiff's failure to meet her evidentiary burden to establish the applicable standard of care for obtaining informed consent. Clark appealed.

The appeals court upheld the decision of the trial court. The court agreed with the plaintiff that North Carolina law ordinarily places a duty for a health care provider to obtain informed consent for procedures and treatment rendered.[14] In determining whether or not the duty to obtain informed consent has been met, the standard of care for that process must be established. Here, the plaintiff failed to produce any evidence of the standard of care. The court concluded: "In particular, plaintiff presented no expert testimony tending to show whether Dr. Perry's actions were 'in accordance with the standards of practice among members of the same health care profession with similar training and experience situated in the same or similar communities' [as required by] G.S § 90-21.13(a)(1). Therefore, as plaintiff did not meet her evidentiary burden with respect to the standard of care element of her negligence allegation against Dr. Perry based upon failure to obtain informed consent, we hold the trial court properly allowed the motion for directed verdict thereon."[15]

Emergency physicians rarely learn how to obtain proper informed consent in a formal fashion. Rather, that particular skill is honed through observation and practice with the result that the process can be quite haphazard and variable yielding a patient consent process that may in truth be both non-informative and non-consensual. Employing a standard, consistent approach with some understanding of the legal requirements can improve the process and provide peace of mind for the emergency physician that at least that aspect of patient care will not result in legal ramifications.

While the practice of medicine is to a large degree standard throughout the United States, the medicolegal aspects of health care frequently are not. Although legal issues governed by federal laws such as the Emergency Medical Treatment and Active Labor Act (EMTALA) and Health Insurance Portability and Accountability Act (HIPAA) do not vary from state to state, those that pertain to malpractice actions do vary because state law governs those claims. In particular, there is significant variation between states on which of the standards discussed above is employed to judge physician informed consent efforts. Therefore, it behooves emergency

physicians to be aware of the informed consent laws in their state. That knowledge can provide the framework for a consistent, legally defensible informed consent process. Although what physicians truly want is immunity from a claim being filed at all, the best that can be hoped for is a robust and winning defense. A physician who can demonstrate an understanding of the legal requirements of proper informed consent and can articulate why those requirements were met is likely to prevail on the issue of whether or not the duty to obtain informed consent was met or breached.

For instance, in North Carolina, the successful physician defendant will be one who effectively testifies that the patient was given sufficient information that would enable a reasonable person to have a general understanding, including risks, of the procedure or treatment and that the information was given in accordance with the standards of practice among members of the same health care profession.

Even so, with the current emphasis on patient autonomy and satisfaction, it is likely that the informed consent process in the ED will receive increased scrutiny along with corresponding heightened medicolegal concerns.

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just come on duty. "The new physician reviewed the first physician's notes, agreed with her assessment and refused to see the plaintiff," says Frew. The patient went to another hospital where he was diagnosed with cauda equina syndrome and had back surgery; he was left with permanent bowel and bladder incontinence. The emergency physician and surgeon settled the malpractice claims prior to trial. The jury found $2.7 million in damages and apportioned 7% liability to nursing actions.

In the ED, the patient hand-off at change of shift is "one of the most dangerous times for a patient," according to **Wayne Guerra, MD, MBA**, vice president of Serio Physician Management, a Littleton, CO-based company that provides management services to hospital-based physicians and hospitals. "The normal vigilance of the physician assuming care is relaxed, since the patient has already been evaluated by another doctor," says Guerra.

According to **Mary A. Cayley, MD, JD,** a medicolegal fellow at Orlando (FL) Regional Medical Center and a member of the American College of Emergency Physician's medical-legal committee, the new provider, whether it be the oncoming ED physician, an admitting physician, or a consultant, must be aware of the the pertinent aspects of the patient's history, exam, and results to ensure appropriate decision-making.

"Communication takes two forms—the verbal sign-out and the ED chart," says Cayley. "No patient encounter or sign-out is complete until the documentation is finished. As much as possible, the ED chart should be complete before leaving at the end of a shift."

Cayley says that the below items are particularly critical to note in a handoff situation:

- Abnormal physical findings of concern;
- All results of labs and studies that are complete, including a comparison to an old EKG, if available;
- Labs and studies that are ordered and are still pending;
- A progress note on the patient, including improvement of pain and normalization of abnormal vital signs;
- Time of any information communicated to a consultant;
- The result of any conversation with a consultant.

"While most handoffs go exactly according to plan, we've all had situations where something unexpected arises," says Cayley. "It is impossible to cover every contingency in verbal sign-out. By ensuring that your handoff charts are appropriately documented, you will give your successor the best possible chance to have the information he or she needs quickly to get up to speed on what you have done for the patient."

Beware of these High-risk Scenarios

Guerra says a particularly high-risk time is when

the disposition of the patient has not yet been determined and is awaiting the result of an outstanding test. For example, the patient has had an abdominal computed tomography (CT) scan that has not been read, and the result will determine if the patient goes home, needs a surgical consult, or needs further testing and admission.

Andrew Garlisi, MD, MPH, MBA, medical director for Geauga County EMS and co-director of University Hospitals Geauga Medical Center's Chest Pain Center in Chardon, OH, says these are all high-risk scenarios during change of shift:

- Any critically ill patient or unstable patient;
- Any patient requiring invasive procedures;
- Patients considering signing out against medical advice;
- Patients who are boarded in the ED and signed over;
- Complex medical/surgical patients managed for several hours by an unsupervised physician's assistant (PA). "The incoming attending physician who must now co-sign the chart and become the 'attending of record,' is now responsible for the work-up, or lack thereof, performed by the PA," says Garlisi.

For complex patients managed by a PA, Garlisi says that the day shift attending should sign off on the chart, and never hand off any unstable patients. "The physician initiating the management of a critical or unstable patient should finish the case," says Garlisi.

Pete Steckl, MD, FACEP, director of risk management for Emerginet, an Atlanta, GA-based emergency medicine management group, says the oncoming ED physician may fail to take ownership of the patient and instead, merely checks pending studies without reexamining the patient. "This is especially critical in more complex patients with potentially dynamic processes such as abdominal pain, chest pain, transient ischemic attack [TIA] and stroke," says Steckl. "These are cases where negative EKGs and negative CTs of the head or abdomen don't necessarily indicate lack of pathology."

Risk is compounded by an accompanying failure to document re-examinations or final results of studies—a common oversight, says Steckl—or to cosign the chart, making it unclear who is making disposition decisions.

At the time of admission, there is often no documentation as to when information was exchanged with admitting doctors. "When suits get filed, it frequently becomes a question of who knew what and when," says Steckl. "I always advise our physicians and practitioners to document timing of discussions with admitting doctors, any abnormalities in vital signs, and clinical findings or labs relayed at the time of admission. It is helpful to document when the admitting doctor agrees to see the patient after admission, especially in unstable patients. This, in my experience, is hardly ever done."

Some Likely Lawsuits

"ED physicians are at greatest risk for a malpractice lawsuit when they fail to diagnose a patient," says Guerra. "In the patient hand-off situation, failure to diagnose most often occurs when the patient's clinical condition has changed and the physician assuming care for the patient fails to recognize this change."

This failure is more likely when the physician assuming care for the patient does not re-evaluate and examine the patient before making a final disposition, says Guerra. To reduce risks, use a formal, standardized process; avoid all interruptions; and introduce the new physician to the patient.

"At a minimum, the exiting doctor should inform the patient her shift is over, and let the patient know the name of the physician assuming care," says Guerra. "Informing the patient he or she has a new doctor demonstrates respect. It prevents the feeling of abandonment that can occur in these situations."

Make every effort to examine the patient within 15 minutes of assuming care. "The transfer of care should be timed and well documented in the medical

Sources

For more information, contact:

- **Stephen A. Frew, JD,** Vice President, Risk Consultant, Johnson Insurance Services LLC, Madison, WI. Telephone: (608) 245-6560. Fax: (608) 245-6585. Email: sfrew@johnsonins.com.
- **Andrew Garlisi, MD, MPH, MBA**, University Hospitals Geauga Medical Center, Chardon, OH. Phone: (330) 656-9304. Fax: (330) 656-5901. E-mail: garlisi@adelphia.net.
- **Wayne Guerra, MD, MBA**, Vice President, Serio Physician Management LLC, Littleton, CO. Phone: (303) 759-0854. E-mail: wayneguerra@comcast.net.
- **Pete Steckl, MD, FACEP,** Director of Risk Management, Emerginet, Atlanta, GA. Phone: (770) 994-9326. E-mail: esquitero@bellsouth.net.

Some Handoff Issues Raise Risk for Malpractice Suits

Stephen A. Frew, JD, vice president and risk consultant with Johnson Insurance Services, a Madison, WI-based company specializing in risk management for health care professionals, says that shift changes or "hand-offs" in care are often associated with malpractice claims, typically for these three reasons:

1. An interruption in the flow of information from the initial provider to the new provider results in a delay, or sometimes loss of the information entirely.

   "Typically, this involves test results or verbal information that is not communicated effectively," says Frew. "Cases often involve an important lab result that came back at shift change that neither physician saw or appreciated."

   In this scenario, the newly responsible physician is almost always the one to whom the liability risk falls. "So, it behooves the on-coming physician to be relentless in seeking out any possible test results that might be overlooked," says Frew.
2. Anecdotal information from the Emergency Medical Services (EMS) crew is lost with a provider change.

   Important information, such as loss of consciousness for several minutes at the scene, isn't communicated verbally to the on-coming team by the original staff. EMS has left the ED, and the EMS record is not readily available in the chart.

   "That leaves the new physician with a potentially dangerous lack of information," says Frew. "I generally recommend that EMS records be immediately available to the ED physician. Then, EMS and triage notes should be reviewed in detail by the ED physician to avoid being tripped up by data in 'someone else's' portion of the chart."
3. During change of shift, off-going physicians just want to wrap up their cases and leave, while on-coming physicians often are tempted to clear out the carry-over cases as quickly as possible and deal with "their own" patients.

"This somewhat common preference to be rid of the 'leftovers,' and the fact that it is sometimes hard to go back to the beginning to put yourself into the same view as the original physician, can be a recipe for problems," says Frew.

record," says Guerra. "For all but the simplest cases, notations should be made by the accepting physician documenting the key aspects of the case."

Steckl says that for admitted patients, lawsuits tend to involve failure to treat what is treatable in the ED. Before leaving the ED, the pneumonia or sepsis patient doesn't receive antibiotics, the deep venous thrombosis doesn't receive anticoagulation, or the TIA patient isn't given antithrombotic therapy.

The expectation is that therapy will be promptly administered by the admitting doctor after admission. However, this "black hole" in initiation of therapy often delays treatment for up to three hours. "This is long enough for the patient to unexpectedly decompensate, thus leading to allegations of delay in treatment on the part of the ED physician," says Steckl.

Discharged patients are most likely to sue on the basis of a lack of information transferred between physicians at the time of checkout, according to Steckl. "This is often compounded by a failure to re-examine the potentially high-risk patient by the oncoming physician at the time of disposition," he says.

Steckl says he is aware of an incident involving treatment of an abdominal pain patient with narcotic pain medications without examining the patient at the time of shift change. "Delays then occurred before the oncoming physician could examine the patient, who by that time had become much sicker from a surgical etiology, decompensated and ultimately died in surgery," says Steckl.

"A push to treat pain early in the ED has led to these types of occurrences," says Steckl. "This incident has led to a directive in our group, to ensure that all patients treated for pain be seen within a reasonable amount of time by the ordering physician."

Steckl says that he has reviewed a couple of cases where well-meaning ED physicians checked out their patients to oncoming physicians with anticipatory pre-filled-out discharge instructions, on the basis of predicted negative pending studies.

"In the spirit of 'no good deed goes unpunished,' these cases backfired on these physicians when

unforeseen bad outcomes occurred post-disposition by the receiving doctor," says Steckl. "To his chagrin, the thoughtful exiting doctor has found himself the erroneously named party in a filed lawsuit, as his name was the only one present on the chart."

The exiting and receiving physicians should take the time for a reasonably in-depth discussion of the case. "This should include clinical impressions, treatment plan, and anticipated potential complications," says Steckl. "Complex patients should be discussed at the bedside, at which time the oncoming doctor can be introduced, and questions can be answered. This allows the off-going doctor to point out key findings. It also serves to reassure the patient and family that important information is not being overlooked in the process of turnover."

Personally notify patients that they will be dispositioned by another physician. "Likewise, the patient's nurse should be notified that the patient is being checked out to the oncoming physician," says Steckl. "This builds in redundancy, so that everyone knows who is to be contactd for questions or to report a change in condition."

CNE/CME *Questions*

40. Which of the following statements is true regarding sovereign immunity?
    A. Sovereign immunity caps damages that maybe awarded in a malpractice lawsuit.
    B. Physicians who render services mandated by EMTALA are automatically granted sovereign immunity.
    C. The idea of sovereign immunity is new.
    D. The concept of sovereign immunity is grounded in the belief that public policy considerations dictate special protection some people or entities if the benefit to society is at issue.

41. Which is true regarding documentation practices to reduce liability risks of "handoffs" in the ED?
    A. If the outgoing ED physician verbally communicates all pertinent aspects on the patient to the oncoming ED physician, written documentation of this same information is not helpful in the event of a malpractice case.
    B. It is not advisable to document the specific time that information was communicated to a consultant.
    C. As long as a formal discussion has occurred with the off-going physician and all studies are negative, documentation of the re-examination done by the oncoming physician is not necessary.
    D. Reexaminations and final results of studies should always be documented on the chart by the oncoming ED physician.

42. Which is true regarding liability risks involving patient handoffs in the ED?
    A. Discharged patients are most likely to sue on the basis of a lack of information transferred between physicians at the time of checkout.
    B. If complex medical/surgical patients are managed for several hours by an unsupervised physician's assistant, the incoming attending physician would not be legally responsible for this patient.
    C. Documenting the exact time that the admitting doctor agrees to see the patient after admission would not be helpful to the ED physician in the event of a lawsuit.
    D. If a sepsis patient fails to receive antibiotics in the ED due to an expectation that therapy will be promptly administered upon admission, the

admitting physician, not the ED physician, is legally responsible.

43. Under American tort law, failure to obtain informed consent is, on its own, enough to warrant a cause of action.
    A. True
    B. False

44. Regarding medicolegal aspects of health care, which of the following statements is NOT true?
    A. EMTALA, HIPAA, *and* state laws on malpractice are consistent from state to state.
    B. While federal laws such as HIPAA and EMTALA do not vary from state to state, those that pertain to malpractice actions do vary because state law governs such claims.
    C. There is significant variation between states on which legal standard is employed to judge physician informed consent efforts.
    D. All of the above statements are true.

45. Which of the following pieces of information should be considered critical to note when a patient is handed off at the end of a shift or upon admission?
    A. Abnormal physical findings of concern
    B. All completed lab results
    C. Information communicated to a consultant and the outcome of conversations with a consultant
    D. All of the above are critical to note.

Answers: 40. D; 41. D; 42. A; 43. B; 44. A; 45. D

CNE/CME Instructions

Physicians and nurses participate in this CNE/CME program by reading the issue, using the references for research, and studying the questions. Participants should select what they believe to be the correct answers, then refer to the answer key to test their knowledge. To clarify confusion on any questions answered incorrectly, consult the source material. After completing the semester's activity, you must complete the evaluation form provided and return it in the reply envelope to receive a letter of credit. When your evaluation is received, a letter of credit will be mailed to you. ■

CNE/CME 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; and
3. Integrate practical solutions to reduce risk into daily practice. ■