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Patients Who Leave AMA: Understand Your Risks and Responsibilities

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Without question, any emergency department (ED) physician who has been practicing in just about any hospital setting has been faced with the patient who wants to leave against medical advice (AMA). In fact, probably sometimes, not too deep down, many physicians even hope that those occasional recalcitrant patients will ask to sign out, especially when the doctor is in the middle of a grueling night shift and the rack of "to-be-seens" seems unending. What better way to clear out the rack than to have a few sign out AMA? But emergency practitioners should be aware of the risks that the AMA patient may present, as well as their responsibilities to limit their liability and ensure the patient's best care.

While there are not many studies that have actually looked at the ultimate liability AMA patients present from a malpractice standpoint to the practitioner or institution, it is intuitively reasonable to assume that these patients do pose at least a moderate risk. The American College of Emergency Physicians (ACEP) and others consider AMA discharges to be high-risk events leading to malpractice litigation.[1] These patients are usually disgruntled for one reason or another; their care has been incomplete, which does not permit the practitioner to get a complete picture of the clinical scenario; and it is questionable as to whether they will follow the

Editor Larry Mellick, MD, Chair-elect of ACEP Pediatrics Section

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Dr. Mellick is on the faculty of the Medical College of Georgia and holds the academic rank of professor in the departments of emergency medicine and pediatrics.

advice you have given them. Of course, some may think that in the legal world of comparative negligence or contributory negligence that the practitioner is somewhat protected, but no physician should ever want to get that far in the discussion.

With AMA, physicians and nurses fear that a patient's condition will deteriorate as a result of incomplete treatment, and risk managers are concerned that the patient will suffer harm to themselves or to others. For these and other reasons, many hospitals have policies and procedures in place on how to deal with the AMA patient.[2] Most hospitals have forms that the patient is requested to sign, and it is usually encouraged that a significant amount of time be spent with the patient who is contemplating AMA. In reality, the patient who is desirous of leaving AMA is generally not given the time that is needed to best protect both the patient and the practitioner/ institution.

For these reasons, it is prudent that the ED practitioner understand how best to deal with AMA. We will discuss AMA from the standpoint of informed consent, or more importantly, informed refusal. We also examine the concept of decisional capacity, go into some of the characteristics of the AMA patient, and finally, explain the medico-legal liability and the ethical obligations and responsibilities that the practitioner has to the AMA patient.

AMA vs. LWBS

First, it is important to make a distinction between AMA and leaving/left without being seen (LWBS). In one study, of 31,252 adult patients who presented during a one-year period, 3% left AMA, and 9% LWBS.[3,4] The statistics vary based on type of hospital and patient population but it is generally found that the AMA rate is anywhere between 2% and 4%,[5,6] and the LWBS rate can be as high as 9%. It is also noted that psychiatric in-patient units may experience AMA rates of 5% to 35%.[5-7] LWBS almost always has to do with waiting times, and AMA has to do with the physician patient interaction.[8]

Informed Consent / Informed Refusal

Informed consent and informed refusal are the basic principles that guide the interaction between the patient and practitioner with respect to medical treatment and procedures. Informed consent is a process, not a form. This process includes the discussion between the physician and patient and the patient's agreement to the proposed intervention. Appropriate documentation of this interaction will help protect the physician in the case of the AMA patient.

In *Schlondorf v. New York Hospital* from 1914, Judge Cardozo stated, "[P]atients have a right to decide what is to be done to their own body and a physician who performs without consent may be liable for battery" and "[T]hose of adult years and sound mind can determine their own health care."[9] This forms the basis of informed consent. The corollary to informed consent is informed refusal, which means that patients who refuse medical treatment or procedures must be informed of the consequences of that refusal.

The informed refusal process is as important, if not more so, than the informed consent process in the AMA patient, because failure to instruct the patient about the potential negative consequence of leaving and the potential determinant to his or her health can be a basis for subsequent litigation if a negative outcome should ensue.

There are three types of informed consent: express, implied, and implied-in-law. Express informed consent is the affirmative granting of authority to render treatment. Implied informed consent is derived from the conduct of the involved parties (e.g., when a patient

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holds out an arm to have blood drawn). Implied-in-law consent is for patients unable to give consent when emergency treatment is indicated to save life or preserve health.

There are two general standards of informed consent: the professional standard, which states that the physician is required to disclose to patients that information that a reasonable minimally competent physician would disclose; and the material risk standard, which states that the physician needs to disclose that which a reasonable patient would consider to be material in making a medical treatment decision.[10,11]

What Needs to Be Disclosed?

The practitioner needs to disclose "that which would be disclosed by the reasonably prudent MD under the same or similar circumstances"; that is, the "reasonably foreseeable" risks and hazards of the proposed treatment, such as:

- The alternatives to that treatment,
- Results likely if the patient remains untreated,
- Dangerousness of procedure, with its incidence of injury and degree of harm threatened, etc., and
- The risk of NOT having the procedure.

There are exceptions to informed consent, as in the case of:

- An emergency where
  - Consent is not practical,
  - The patient is incompetent,
  - No alternative decision maker is available, or
  - In the case of the reasonable prudent patient, where the patient had knowledge about the risk or would have undergone the procedure even without informed consent;
- Common knowledge—that is, any reasonable person has knowledge about the risk;
- Waiver—the patient indicates desire to not want to know; and
- Therapeutic privilege—where the physician decides it is in the best interest of the patient (Caution: You need an expert to testify that "almost no one could handle this information" and that the physician was justified in using the therapeutic exception).[10]

As with informed consent, informed refusal is a *process,* not simply a signature on a form. The practitioner must:

- Make a determination of decisional capacity;
- Deliver the appropriate information, including risks of refusing treatment; and,
- Most importantly, document the process.

Simply because a patient elects to leave AMA does not mean that he or she is always entitled to do so. In fact, there are situations in which the practitioner is mandated to override the patient's refusal to stay (i.e., not permit a patient to leave AMA), such as when the patient is: expressing suicidal ideation, lacks decisional capacity, is a danger to others, or poses a public health risk (e.g., active tuberculosis and refusing treatment).

Decisional Capacity

The most important factor in determining whether a patient can leave AMA is deciding if he or she has decisional capacity. Capacity is an essential element in the process of informed consent and informed refusal. It involves the concepts of competency and capacity. Competency is a legal term, and technically, a patient is competent until a court says otherwise. If the patient is deemed incompetent, the court then appoints a guardian. Capacity is a decision that is made by a physician and is a subjective determination based on an evaluation.

Decision-making capacity refers to a patient's ability to make an authentic choice. It reflects cognitive and affective functions, which are clinically manifest in intellect, memory, judgment, insight, language, attention, emotion, calculation, and expressive and receptive communication skills.[5] The patient must be able to receive information; process and understand the information; and evaluate, deliberate, and then articulate and communicate a decision.[5,12]

In addition, there is a "sliding scale" of decisional capacity ranging from those with complete capacity (i.e., the adult with normal mental status), to those with some capacity (i.e., patients at the end of life with metabolic abnormalities, disorientation, or early dementia), to those with no decisional capacity (i.e., the comatose patient, infants, and the profoundly mentally disabled). It should be noted that intoxication, whether influenced by drugs or alcohol, is NOT an absolute bar to capacity.

Some have even argued for a flexible standard when it comes to decisional capacity, such that as the risk of harm increases, the criteria for decisional capacity should increase and become more stringent.[13]

When faced with this capacity issue, the practitioner should use a stepwise approach, as follows:

1. Ensure the ability to communicate.
2. Correct reversible environmental, metabolic, mental and physical challenges to capacity.
3. Utilize standardized tests of competency, when appropriate.
4. Survey patient goals and values using open-ended questions about the choices (including risks and benefits), and alternatives (including the option not to treat), and consequences.
5. Communicate with the patient and his/her health care advocates, if present.

6. Document essential elements of capacity or its impairment in the medical record.

Sometimes there exist true barriers to a patient's decisional capacity, such as: status as a minor; advanced age or dementia; intoxication and/or psychiatric conditions; the patient in extremis; cultural or language barriers; physical communication impairments; severe pain; and organic disease states.[5] When a patient's capacity is impaired, there is a hierarchy of who makes the decisions for the patient: Spouse, then children, then parents, and then siblings. If none of these exist, the court will appoint a guardian for the patient and will use the legal term "substituted judgment" to have someone act in a way that is deemed in the best interest of the patient.

AMA Characteristics and Myths

Most patients believe that the insurance company will not pay for their visit if they leave AMA. This is a myth; however, insurance may not pay for a repeat visit for the same symptoms.[14]

Multiple studies have shown that there are certain characteristics of the AMA patient. These patients are generally younger males, the uninsured, those with past histories of leaving AMA, those with histories of drug or alcohol abuse, and those with psychiatric diagnoses.[4,5,15,16] With respect to inpatient AMAs, there also seems to be a correlation with dates of issuance of welfare or relief checks, and there is a preponderance of AMAs during the evening and night shifts. As far as the provider relationship, there is a direct relationship between the failure of establishment of a supportive provider–patient relationship and increased AMA rates and a failure to orient patients to the hospitalization.[5]

It is also seen that AMAs have higher death rates, worse health outcomes, higher rates of future admission/readmission, longer subsequent stays, and higher resource utilization.[5,7,17,18] One study revealed that subjects who left AMA were significantly more likely to have an emergent hospitalization within the first nine days compared with subjects who LWBS. During the 30-day follow-up period, subjects who left AMA were significantly more likely to return to the study ED and be emergently hospitalized (4.4%) compared with those who LWBS (2.6%).[4]

There are a number of reasons that patients choose to leave AMA, including:

- Noncompliance with exams, tests, procedures;
- Family pressures/responsibilities;
- Drug/alcohol dependence;
- Feelings of panic;
- Personality disorder;
- Preference for treatment elsewhere;
- Psychotic behavior;
- Phobic feelings; and
- Other reasons (e.g., financial concerns, anger, disagreement with the treating physician, fear of expense, fear of pain, and fear of serious diagnosis.[5,6,15]

A study conducted at the medical service of a Canadian urban hospital found that patients left due to personal or family matters, feeling well enough to leave, dissatisfaction with treatment received, feeling bored or fed up, dislike of hospitals in general, and miscellaneous other reasons.[6]

The top diagnoses of the AMA patient were found to be: nausea and vomiting, abdominal pain, nonspecific chest pain, alcohol-related mental disorders, headache, including migraine, other lower respiratory disease (e.g., dyspnea, lung abscess, and so on), other connective tissue disease (e.g., rheumatism), spondylosis, intervertebral disc disorders, other back problems, other nontraumatic joint disorders (e.g., arthropathy, joint effusion), and asthma.[4]

Medico-legal Risks of AMA

Gregory Henry, MD once said that one of the major purposes of the patient chart is to turn the white paper into green money for the practitioner and hospital, and that it can also be said that the plaintiff's attorney has the same goal in mind; that is, to turn the white paper of the chart into green money for himself and his client.[14] The practitioner must be aware of this and do all that is possible to limit liability exposure and best serve the interests of his or her patients.

It has been estimated that 1 in 300 AMA patients will file a lawsuit.[2] It is generally felt that these suits fail because courts are not sympathetic to those who refuse medically recommended treatment. However, the best way to protect oneself down the line is through appropriate, contemporaneous documentation in the chart. Doing so can provide partial or complete protection from a lawsuit.[14,19]

So why are these claims brought? Usually, it is due to the haste; the busy ED practitioner fails to do what needs to be done in the AMA case. This may be due to the fact that the AMA form was given by a nurse or physician's assistant with no physician involvement; the patient was not warned about his/her specific medical condition and the risks of leaving AMA; there was inadequate documentation of the process; no family involvement in the process; questionable medical competence of the patient; inappropriate aftercare instructions; or any combination of the above.[20]

It has been shown that, for the most part, physicians typically do NOT document assessments of capacity in AMAs.[7] In one study, AMA documentation was noted in 82% of cases reviewed; however, only 23% included documentation regarding the patient's decisional capacity.[5,21] This failure to document capacity is

Table 1. Sample AMA statement

"Despite our efforts, [*PATIENT'S NAME*] has decided to leave against medical advice (AMA). He/she has a normal mental status and full decisional capacity. The patient understands his/her condition (be specific) and the risks of leaving AMA, including BUT NOT LIMITED TO permanent disability, death, etc., and has had an opportunity to ask questions about his/her medical condition. The patient's (husband, wife, child), [*NAME OF FAMILY MEMBER*], is also aware of the condition and the patient's desire to leave AMA. The patient has been informed that he/she may return for care at any time, and has been referred to his/her local medical physician for follow up ASAP."

Table 2.

Disease risk	Treatment efficacy	Treatment risk	Ethical obligation
High	**High**	**Low**	**Clear**
High	Low	Low	Weak
Low	High	Low	Weak
High	High	High	Not clear
High	Low	High	Not clear
Low	High	High	Not clear
Low	Low	Low	Not clear
Low	**Low**	**High**	**Do Not Treat**

Source: Berger J. Discharge AMA: Ethical consideration and professional obligations. *J Hosp Med* 2008;3:403-408.

often the basis of a plaintiff's verdict in AMA cases.

How to Limit Liability

So what is the best way to limit one's liability? Simply put, the single best way is by proper documentation in the medical record—regardless of the extra time required. In fact, a Georgia case demonstrated that documentation could be an issue in refusal of care. The court said that "failure to make a notation of such an important event as refusal of necessary treatment casts doubt upon... contention that it did in fact occur."[22]

In addition, most institutions have forms releasing hospitals and providers from liability. The practitioner should be aware that these boilerplate forms have been deemed invalid and against public policy.[5] It is therefore recommended that in addition to having the patient sign the standard form on the chart, the physician should spend the brief amount of time necessary to write out the AMA language and have the patient and witness(s) sign the note.

It is not too difficult to document the basic elements of an appropriate AMA discharge, including:

1. Decisional capacity;
2. The physician's opinion regarding why the patient should stay;
3. The physician's ongoing concern about the patient leaving;
4. The informed refusal, including possible outcomes and alternatives;
5. Family who are present and aware of the condition;
6. Any other efforts: i.e., family, social work, nursing supervisor involvement, etc.; and
7. Signatures from the patient and witness(es).[20] *(See* **Table 1** *for a sample AMA statement.)*

To reiterate, when a patient refuses care, the wise practitioner can and should:

1. Ascertain adequate decisional capacity;
2. Assess patient's values and application to the situation at hand;
3. Address the patient's concerns;
4. Inform the patient of the risks of refusal of care;
5. Involve other parties, when appropriate (family, social work, patient advocate);
6. Consider alternative treatment(s);
7. Provide appropriate care and follow-up information, when possible;
8. Avoid punitive statements and scare tactics;
9. Document the informed refusal discussion and outcome; and
10. Consider telephone follow-up.[5,23]

Ethical Considerations

What are the physician's ethical obligations? For example, how does the physician respect patients' choices and prevent harm? What are the physicians' obligations to their patients who leave with inadequate treatment plans or no treatment at all? When should the physician question the decision-making capacity of the patient who makes the AMA decision? As a hypothetical, does the debilitated, dependent, yet competent patient have the right to return home to an unsafe situation?

Physicians are faced with two confronting ethical obligations: the duty to promote a patient's well-being and protect them from harm, and the duty to respect the wishes of the patient. The viewpoint on this has changed from 100 years ago, when it was felt that the patient should be obedient to the wishes of the physician. Most recently, in 2001 the American Medical

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The Duty to Warn Third Parties in Emergency Medicine

By **Jason D. Heiner, MD**, MC, USA, Department of Emergency Medicine, and **Gregory P. Moore, MD, JD,** Attending Physician, Emergency Medicine Residency, Madigan Army Medical Center, Tacoma, WA.

The confidential nature of the therapeutic relationship between physician and patient is an integral component of the practice of medicine. The landmark *Tarasoff* case established a legal duty for a physician to breach this confidential relationship to warn third parties from foreseeable violence. In this article, the authors review this case and how the duty to warn third parties has extended beyond cases involving violence to include foreseeable harm from medication side effects and infectious disease.

Origins of the Concept

An expectation of confidentiality between physician and patient is an essential component of the therapeutic relationship. This duty to maintain confidentiality enables the transfer of potentially sensitive patient information to best serve the patient. The landmark case of *Tarasoff v. Regents of University of California* established a new duty for a physician to warn a third party regardless of this obligation of confidentiality, concluding that the "protective privilege ends where the public peril begins."[1]

In 1969, Prosenjit Poddar was briefly detained by campus police on the request of his psychologist, Dr. Moore, after confiding his intention to kill Tatiana Tarasoff. Neither the victim nor her parents were warned before Poddar successfully carried out his deadly threat. In *Tarasoff v. Regents of University of California* (1976), Tatiana Tarasoff's parents argued to the California Supreme Court that their daughter's death occurred after Dr. Moore and others negligently failed to warn them.[1] They alleged that the therapists predicted that Poddar would kill, and that harm to a third party (Tatiana) was foreseeable. The court found that the therapists not only had a duty to their patient, but also had a duty to warn a third party of foreseeable violence.

The physician's duty to warn a third party of violence has been subsequently supported since *Tarasoff*. In *Dorothy McGrath et al v. Barnes Hospital, et al*, a paranoid schizophrenic being treated in an inpatient setting admitted several times to having thoughts of stabbing his mother.[2] Reportedly, he had made this statement many times in the past, so no attempt was made to warn his parents. The night that he was released to the care of his parents, he stabbed both of them, killing his father and severely injuring his mother. The hospital was sued by the patient's mother for failure to warn. She was awarded $2 million, despite a defense that the family was already aware of this risk of violence given his long history of mental illness.

Key to these cases are the issues of foreseeability and the special relationship existing between a physician and his or her patient. The *Tarasoff* decision declared that the physician has a duty not only to the patient, but also to other third parties. In the cases described above, the threats of violence created foreseeable harm to a readily identifiable victim. This concept of foreseeable danger to a third party can be applied even when a victim is not readily identifiable. For example, if a patient declares, "I am going to kill someone in the hospital microbiology lab," this threat is not specific but does indicate a foreseeable danger. However, if the same patient declared, "I am going to kill someone in the United States Army," a non-specific threat without useful foreseeability has been made. It would be practical to warn a small lab, but not the entire United States Army. The concept of foreseeable danger has also been applied when harm has been due to the consequences of medications and infectious disease rather than violence.

***Tarasoff* on Medications**

Courts have variably applied the *Tarasoff* concepts to subsequent cases regarding harm secondary to medications. In the *Tarasoff* opinion, it was stated not only that "a hospital must exercise reasonable care to control the behavior of a patient which may endanger other persons," but also that a "doctor must also warn a patient if the patient's condition or medication renders certain conduct, such as driving a car, dangerous to others."[1] This opinion was honored in *Myers v. Quesenberry* (1983) after a diabetic patient who was prescribed insulin struck a pedestrian during a hypoglycemic episode.[3] When the third party pedestrian argued that he was a foreseeable victim, liability was imposed on the doctor who did not warn the patient of a potential impaired ability to drive secondary to her condition.

Alternatively, the *Tarasoff* opinion has been dismissed in similar contexts. In *Kirk v. Michael Reese Hospital and Medical Center* (1987), a patient prescribed fluphenazine and chlorpromazine consumed alcohol and struck a tree

while driving, injuring the car's passenger.[4] The passenger sued the prescribing physician, but liability was not imposed on a physician when the court found that the physician had no duty to the passenger, who was not a foreseeable victim.

In a recent case, *McKenzie v. Hawaii Permanente Medical Group, Inc*. (2002), the *Tarasoff* opinion was again upheld.[5] Three days after being prescribed prazosin hydrochloride to treat hypertension, a patient fainted while driving and struck a pedestrian, Kathyrn McKenzie. The court ruled that a "physician owes a duty to non-patient third parties injured in an automobile accident caused by an adverse reaction to the medication prescribed…where the physician has negligently failed to warn the patient that the medication may impair driving ability and where the circumstances are such that the reasonable patient could not have been expected to be aware of the risk without the physician's warning."

Tarasoff on Infectious Diseases

Tarasoff stated that "a doctor is liable to persons infected by his patient if he negligently fails to diagnose a contagious disease, or, having diagnosed the illness, fails to warn members of the patient's family."[1] In this context, the *Tarasoff* opinion was honored in *DiMarco v. Lynch Homes– Chester County, Inc* (1990).[6] In this case, a physician counseled a patient (a lab technician accidentally exposed to hepatitis B after a needle stick) to refrain from sexual relations for six week, and that if she was symptom-free for six weeks, she was not infected with the virus. After eight symptom-free weeks, she resumed sexual relations with her boyfriend and both the patient and her boyfriend were later found to be infected with hepatitis B. The patient's boyfriend alleged negligence in failure to warn that sexual relations within six months could expose him to the disease. The court found that the physician's duty encompassed such a third party who was "within the foreseeable orbit of risk of harm" to such a sexually transmitted disease.

In *Britton v. Soltes* (1990), the *Tarasoff* precedent in the context of infectious disease was not accepted.[7] In this case, a doctor was charged with negligence after failing to diagnoses a man with tuberculosis whose ex-wife and children later contracted the disease. While the man did live near his ex-wife and children and visited them often, the court concluded that the physician did not have a special relationship with the patient's family. They stated that "the defendant's duty of care will not be so extended, since there is no indication of the point where the duty would end."

Recently, in *McNulty v. City of New York* (2003), a friend of a patient with infectious meningitis alleged that she approached doctors who had treated the patient and asked whether she needed prophylactic treatment.[8,9] She claimed that the doctors did not counsel her to seek treatment and the physicians who were sued claimed that she was told to see her personal doctor. She was subsequently diagnosed with meningitis and suffered serious hearing loss. A lower court found that the doctors had a legal duty to warn the friend. However, on appeal it was ruled the injury did not result from the doctors' performance of the duty of care owed to the patient with meningitis, and no relationship was established.[9]

Conclusion and Recommendations

The *Tarasoff* case has implications beyond the duty for physicians to warn third parties of foreseeable violence. The courts continue to honor the *Tarasoff* opinion in other areas of public health, such as harm to third parties due to medication side effects and infectious disease. It behooves clinicians to be familiar with their states' laws, as not all states honor this decision and disagreement may even exist within a state. Fortunately, a simple alternative would be for physicians to educate a patient about their disease, the potential serious medication side effects, the risks of their infectious disease, to inquire about others who may be at-risk close contacts, and make a reasonable attempt to warn a third party of when a real threat appears to exist. Realize that this liability can be shifted to the patient themselves by simply directing and optimally documenting, "you should not drive or do dangerous activities while on this medication," or "you should warn others of your infectious disease and avoid exposing others to your infectious disease." With this in mind, it is not an unreasonable burden to comply with the intent of *Tarasoff* regardless of a state's current opinion of this landmark case.

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Association's Principles of Medical Ethics state that, "A Physician shall respect the rights of patients…"[13]

However, to understand these rights we need to understand that the decisions of patients are different than what drives the decisions of physicians. The patient's decisions are often driven by their personal values and their broader interests, whereas, by and large, the physician's decisions are driven by well-defined medical goals. The physician has the overall responsibility of promoting patients' welfare, beneficence (while respecting their autonomy), serving the patient's self-defined best interests, maintaining dignity, and providing objective assessments of harm and benefit.[7]

In making a proper assessment, the physician should identify the patient's compelling reason for leaving. Is there an ill or demented spouse alone at home? Are there cultural or religious requirements that they perceive cannot be met while hospitalized? Is there a concern about loss of employment? What about an important family obligation that needs to be fulfilled, such as a wedding or funeral? Are there overriding financial concerns? Only when you truly get to the source of the reason can you be the best assistance to your patient.

Some argue that there is an ethical obligation to treat a patient who has a high disease risk, where the treatment efficacy is high and the treatment risk is low. In contrast, there is an ethical obligation to NOT treat where the disease risk is low, the treatment efficacy is low, and the treatment risk is high; and then there are the permutations somewhere in between. *(See* **Table 2***.)* Different scenarios will dictate the decisions; it is unlikely that there is an absolute right or wrong answer in this regard.

So what should the physician provide for a patient who wants to leave AMA? From a best-practice standpoint, if possible: Give the patient a specific follow-up appointment at the time of departure; ensure that the patient receives appropriate prescriptions (or, preferably, the medications themselves); provide the patient with appropriate discharge instructions; and if feasible, a follow-up by telephone call would be desirable, since patients who leave AMA often lack a primary care provider and are likely to miss follow-up appointments.[18]

Summary

The AMA patient may, on first glance, be a relief to the busy ED practitioner. However, the future implications of the AMA patient may cause the physician to have unnecessary anxiety, lost sleep, fear of litigation, and concern about the ultimate welfare of the patient. The prudent physician would be wise to do all that he or she can to ensure the proper information has been communicated to the patient. Proper and appropriate documentation of decisional capacity and the other steps enumerated above will go a long way in protecting the practitioner from subsequent litigation, and also will protect the AMA patient from potential subsequent harm.

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If You Apologize, Are You Likely to Be 'On the Hook' for a Lawsuit?

Most experts say risks are reduced

(Editor's Note: This is the first in a two-part series on disclosing errors to emergency department patients. This month, we cover whether liability risks are, in fact, decreased by this practice. Next month, we will give specific strategies to reduce liability risks when apologizing to a patient.)

A few hours after a chest pain patient was worked up and discharged with a non-cardiac diagnosis in a Virginia ED, he was brought back dead on arrival. According to the family, the ED physician got down on his knees in front of the man's wife and begged for forgiveness for missing the diagnosis. The family sued the ED physician, and the case was settled out of court.

The above case happened years before "I'm sorry" legislation was enacted in the state. Interestingly, however, had the law been in existence, it might not have made any difference whatsoever.

"It's possible that we might have been able to keep that out of evidence under the statute, but I am not optimistic," says **Joseph P. McMenamin, MD, JD, FCLM**, the attorney who defended the ED physician. McMenamin is a partner at Richmond, VA-based McGuireWoods and a former practicing emergency physician.

"The statute has to be obeyed to the letter. You have to be very careful with what you say and how you say it," explains McMenamin. "I suspect the physician still would have been faced with admissible evidence. And that was pretty damaging."

If the apology is brought in as evidence, and exaggerated or distorted by the patient or family, the defense attorney can certainly challenge the accuracy of their account. "I can put my guy on the stand to say what really happened. But if the jury decides to disbelieve what Doctor X has to say, you're stuck with that. The mere fact that the family says it means the jury gets to consider it, and might believe it," says McMenamin. "And a jury hearing that the doctor said he's sorry may think he's basically admitting he was wrong. That may be what they hear."

Are Risks Really Reduced?

Massachusetts is among the states providing statutory protection for providers apologizing for an unfortunate patient outcome. The statute says that such statements are inadmissible in civil cases. "My office routinely files a motion in limine at trial to preclude any statement of apology or sympathy. These motions are routinely allowed," says **J. Peter Kelley, JD**, a health care attorney with Cambridge, MA-based Foster & Eldridge. "Having this protection, we advise providers in certain circumstances to express sympathy and/or apologize to the patient and family for unfortunate medical results."

Kelley adds that in his experience, disclosure doesn't make the defense more difficult. "Motivation for litigation is fueled by a patient or family feeling the provider is uncaring or dismissive of the bad outcome," he says. "Appropriate disclosure and expressions of sympathy, if properly communicated, can reduce the likelihood of a claim."

Richard C. Boothman, chief risk officer at the University of Michigan Health System in Ann Arbor, says that "I'm sorry laws," in his opinion, haven't been around long enough to be tested. "I don't think that they offer guaranteed protection against the potential abuse of an apology," he says. However, Boothman says that being honest in these situations can reduce your liability in many ways, including diffusing anger. "It can allow the parties to move toward reasonable compensation and emotional closure without the expense, both financial and emotional, of litigation," he says. "When an apology is owed, every day that passes without one causes a new injury. The price to resolve the dispute only rises as time passes."

On the other hand, if in fact an apology is not owed, failing to discuss this with the patient can cement misunderstandings and misconceptions. This can lead to unfounded litigation. "It is always better to avoid a lawsuit, than to win one that never should have been filed in the first place," says Boothman.

However, McMenamin isn't convinced the situation is so clear-cut. "As a defense guy, I don't mind admitting that these statutes give me the willies," he says. "Understanding what the law is on a topic might not necessarily be a walk in the park. Sometimes it's very difficult to figure out what the legislature had in mind. After all, why do we have judges? And if it's a statute that's pretty new, we don't have a lot of case law to point to."

McMenamin adds that even if an ED physician is a scholar of the law, at 2 a.m. when he is trying to figure out what to say to somebody about a maloccurence, he's unlikely to take into consideration any case law that has interpreted the meaning of a statute.

Emory Petrack, MD, FAAP, FACEP, president of Cleveland, OH-based Petrack Consulting, says that while ED physicians frequently apologize about minor issues such as delays in X-ray results, apologies for more serious issues are uncommon in his experience.

"However, I have made apologies myself for medication dosing errors," he says. "Fortunately, while the error was significant-a nurse giving an excessive dose of ibuprofen—there were no expected clinical manifestations."

Petrack says that whether error disclosure to patients can in fact prevent a lawsuit, is "the $64,000 question. In general, I do believe that honesty in communication, which includes acknowledging errors made, is the right thing to do."

With a serious error that is likely to be discovered anyway, failing to be clear about what happened, including a possible apology, may only make the situation worse. "That said, if it were a very serious error, after the clinical concerns are handled, I'd probably contact risk management to bring them quickly in the loop," says Petrack.

If you do apologize, do so with another health care provider in the room. "If it ends up becoming an issue, and there's a deposition or other investigation, the hospital now has two 'witnesses' to the discussion," says Petrack.

Should Mistakes Ever Be Hidden?

"I think it's pretty clear that if you hide a mistake and then somebody finds it, you are probably at much greater risk of losing a case," says **Peter Viccellio, MD, FACEP**, vice chairman of the department of emergency medicine at the State University of New York at Stony Brook. "A classic example of that would be somebody doctoring a chart. It is seen as proof of guilt."

Rather than training everyone in the ED in how to disclose mistakes to patients, Viccellio recommends designating individuals in the department or hospital. "If someone came to harm in my department, I would feel it most appropriate for me to sit down and talk to them," he says.

Viccellio points out that anytime a patient is called back for a misread CT scan, it constitutes an admission of error. However, other mistakes would never be known by the patient, unless they were told. "Some things you can bury," says Viccellio. "So the question becomes, if I did something that harms a patient and I can hide it, then should I? I meant to give you dexamethasone and instead you got a high dose of methotrexate, that may not give you any manifestations now. But it may increase your risk of cancer down the road."

Viccellio says that in his ED, "if we believe we did something to a patient where there was actual harm and it was our fault, as far as not disclosing it to the patient, I don't think we consider that as an option. We would feel compelled to inform the patient."

Viccellio says that with error disclosure, the question isn't whether or not it influences juries. "The question is whether or not your actions influence whether it ever becomes a malpractice suit to begin with," he says. "Most people, in fact, don't sue after a medical mistake. The statistics are in your favor. But most studies suggest that an angry person is more likely to sue. And if I hide something from them and they find out, I think it's much more likely that they would sue, or try to sue."

Viccellio acknowledges his frustration with the lack of legitimacy of many ED malpractice cases. "But because that's a problem doesn't mean that therefore we're entitled to lie about what we do," he says. "The fact is, there are terrible problems with the system of litigation. But does that excuse us for being dishonest with our patients about errors that we make? To me, the answer is no."

Even mistakes that have no consequence are a "slippery slope," according to Viccellio. He gives the example of a patient who was in cardiac arrest for 30 minutes before they arrived in the ED. It's later discovered that the endotracheal tube placed in the ED, long after the patient had any chance of survival, was in the esophagus instead of in the airway, Whether there is a legitimate purpose in informing the family of such events, which had no chance of altering the outcome, is a matter of controversy.

However, the situation is different for a child who was intubated with the endotracheal tube in the esophagus, got no oxygen for about 10 minutes and is severely disabled, possibly as a result of the mistake. "That's an example of something that the family might not ever know unless you told them," says Viccellio. "And if you do tell them, it does introduce the possibility of a $10 million payout. Still, how is it right not to tell them?"

CNE/CME *Questions*

46. The process of informed *refusal* includes which of the following steps?

    A. Determination of decisional capacity
    B. Delivery of appropriate information, including risks of refusing treatment
    C. Documentation of the process
    D. All of the above

47. Which of the following has NOT been shown to correlate with inpatients leaving against medical advice (AMA)?

    A. Issuance of welfare or relief checks
    B. Established, supportive provider-patient relationship
    C. Failure to orient patients to hospitalization
    D. Evening and night shifts

48. Regarding duty to warn third parties, courts have consistently rejected the *Tarasoff* opinion in cases involving harm to third parties due to medication side effects and infectious disease.

    A. True
    B. False

49. When a patient may prove a danger to a third party, the concept of foreseeable danger can be applied even when a victim is not readily identifiable.

    A. True
    B. False

50. Which is recommended regarding liability risks and apologizing to patients?

    A. If an ED physician apologizes to a patient, this should be done with another health care provider in the room as a witness.
    B. "I'm sorry" legislation means that apologies cannot be introduced as evidence under any circumstance.
    C. EDs should avoid designating specific individuals to disclose errors to patients.
    D. Even non-injurious mistakes should always be disclosed to patients.

Answers: 46. D; 47. B; 48. B; 49. A; 50. A

CNE/CME Objectives

After completing this activity, participants will be able to:

1. Identify legal issues relating to emergency medicine practice;
2. Explain how these issues affect nurses, physicians, legal counsel, management, and patients.
3. Integrate practical solutions to reduce risk into the ED practitioner's daily practices. ■

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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. ■

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