ED Legal Letter™

The Essential Monthly Guide to Emergency Medicine Malpractice Prevention and Risk Management

From the publishers of *Emergency Medicine Reports* and *ED Management*

AHC Media

Financial Disclosure: The following individuals disclose that they have no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study: Arthur R. Derse, MD, JD, FACEP (Physician Editor), Director and Professor, Center for Bioethics and Medical Humanities, Institute for Health and Society, Medical College of Wisconsin, Milwaukee, WI; Kevin Klauer, MD, Chief Medical Officer, Emergency Medicine Physicians, Canton, OH; Stacey Kusterbeck (Contributing Editor); Shelly Morrow Mark (Executive Editor); and Leslie Hamlin (Managing Editor). Kay Ball RN, PhD, CNOR, FAAN, Consultant/ Educator, K&D Medical Inc., Lewis Center, OH (Nurse Planner) is a speaker for AORN and a stockholder for STERIS, Inc.

April 2013
Vol. 24 • No. 4• Pages 37-48

Informed Refusal: Just as Important as Informed Consent

By Kevin Klauer, MD, Chief Medical Officer, Emergency Medicine Physicians, Canton, OH

Informed refusal is the antithesis of informed consent, a natural extension of the doctrine. Informed consent is discussed in great detail in the medical, legal, and risk-management literature; whereas informed refusal has received less attention. Certainly, informed consent is critical to recognizing patient autonomy, protecting the patient's status as a human being, and providing a means for rational decision making while protecting the health care provider from risk associated with misaligned expectations.[1] The informed consent process deals with the provision of appropriate disclosure of risks and benefits of a proposed treatment, often in patients who are relatively likely to accept the proposed treatment. In other words, if a patient is having an informed discussion about a proposed treatment, it seems logical that the patient is expressing interest in the suggested treatment and is seeking the necessary information to make a rational, informed decision. Quite the contrary, when a patient is not interested in the procedure and is not engaged in the informed consent process, adequate attention may not be paid to obtaining an informed refusal. The concern is that the informed refusal process is not approached similarly or regarded with the same degree of importance as informed consent.

The basis for informed consent is from common law, emphasizing that "every human being of adult years and sound mind has a right to determine what shall be done with his own body."[2] In this context, informed consent was applied in terms of battery, as opposed to the current and more appropriate context, the tort of negligence. In the 1960s, this doctrine further evolved to include that information be provided about the associated risks of the proposed treatment and any treatment alternatives that may be available.[3] In 1972, *Canterbury v. Spence* further defined this concept

by using the "reasonable patient" standard to define the scope of required disclosure. Although every obscure detail or remote risk need not be disclosed, the practitioner must disclose what a reasonable patient would want to know about a particular treatment or procedure.[4] The patient, Mr. Canterbury, was to have a laminectomy performed. However, despite the physician's knowledge that the procedure may result in paralysis in 1% of patients, he did not disclose this risk. The patient had the procedure and then fell out of bed, resulting in paralysis. Although it is not possible to know if the fall or the procedure was the cause of his paralysis, this case placed the focus on the patient, identifying the need to recognize that a material risk is one that a reasonable person would consider a risk.

ED Legal Letter™, ISSN 1087-7347, is published monthly by AHC Media, 3525 Piedmont Road N.E., Bldg. 6, Suite 400, Atlanta, GA 30305. Periodicals Postage Paid at Atlanta, GA 30304 and at additional mailing offices.

POSTMASTER: Send address changes to ED Legal Letter, P.O. Box 105109, Atlanta, GA 30348.

Subscriber Information: Customer Service: (800) 688-2421. Customer Service E-Mail Address: customerservice@ahcmedia.com. Editorial E-Mail Address: leslie.hamlin@ahcmedia.com. World Wide Web: http://www.ahcmedia.com. Subscription Prices: United States: $499 per year. Add $17.95 for shipping & handling. Multiple Copies: Discounts are available for group subscriptions, multiple copies, site-licenses or electronic distribution. For pricing information, call Tria Kreutzer at 404-262-5482. Canada: $529 per year plus GST. Elsewhere: $529 per year. Back issues: $83. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue's date. GST Registration Number: R128870672.

AHC Media is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

AHC Media designates this enduring material for a maximum of 18 *AMA PRA Category 1 Credits*™. Physicians should claim only credit commensurate with the extent of their participation in the activity.

Approved by the American College of Emergency Physicians for a maximum of 18.00 hour(s) of ACEP Category I credit.

AHC Media is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

This activity has been approved for 15 nursing contact hours using a 60-minute contact hour.

Provider approved by the California Board of Registered Nursing, Provider #14749, for 15 Contact Hours.

This activity is intended for emergency physicians and nurses. It is in effect for 36 months from the date of the publication.

AHC Media

Questions & Comments
Please contact **Leslie Hamlin, Managing Editor**, at leslie.hamlin@ahcmedia.com.

Furthermore, a physician is to recognize the patient's position. Thus, recognizing what a reasonable person would consider a risk and would need to know in order to make an informed decision is critical to this process.

A modern day corollary to the previous examples is the current debate regarding whether or not consent is needed for the delivery of tPA for ischemic stroke. There is growing popularity in the belief that because tPA is the standard of care, consent is no longer necessary. Such statements only reflect a fundamental misunderstanding of both the concepts of standard of care and informed consent. These two legal terms are related, but are mutually exclusive, except when considering the standard of care for the process of obtaining informed consent. This concept will be addressed shortly.

First, let's define standard of care. A standard of care is what a reasonable provider with similar training, in a similar situation would do. It can be easily debated whether tPA is truly the standard of care, particularly with ongoing debate and controversy regarding its safety and efficacy. Let's suppose for a moment that the debate had been settled and tPA administration is undoubtedly the standard of care, and not to offer or deliver the drug would be deemed below that standard. Would this obviate the need to inform the patient about the risks of the drug, obtaining their consent? Absolutely not.

Some less complex procedures or treatments do not require obtaining specific informed consent. In many circumstances, the treatment provided, and its associated risks, are intuitive to the patient and general population. In other words, it's common knowledge, and a reasonable person would understand the risks and benefits. For instance, when a patient presents to the emergency department with a facial laceration, we accept their general consent for treatment as their consent for the procedure as well. The reason is that most reasonable patients understand that the wound will be inspected, cleansed by some means, and closed. This is such a commonly understood process that additional consent just isn't necessary. However, if the provider decides that using moderate sedation will be necessary, consent would be required for providing the sedation.

In contrast, the risks associated with proce-

dural sedation are not intuitive and need to be explained. Once the informed discussion has occurred, the patient can make a reasonable decision whether he or she would like sedation or not. Another way to look at this is that informed consent is less likely if the patient presents with a specific expectation and the provider does not deviate from those expectations. If the patient presents for a laceration repair and procedural sedation is not added into the equation, then consent for the repair is not required. Although some may disagree, I would extend this same theory to shoulder dislocations.

I suspect that common practice is to consent for the sedation, when necessary, but not for the reduction itself. This seems to make reasonable sense, as the reasonable patient with a shoulder dislocation understands, in general, that he or she would like to have it put back in place and that reasonable care will be taken to perform the procedure safely and effectively. For the same reason, consent is not needed for a laceration repair. I believe it isn't necessary to obtain patients' consent for other obvious procedures without unknown risk (i.e., intravenous line insertions, urinary catheter insertions, etc.). Providers have to be careful not to extend this theory beyond its scope. The procedures we perform become very familiar to us, as do their indications and potential complications. However, what is routine for us may be novel, complex, and otherwise non-intuitive to the average person. A lumbar puncture, for example, is a fairly safe test, and it is frequently performed in emergency medicine, so frequently that we may refer to it as routine. Although rare, complications can occur, and most patients want to be informed about those potential complications before agreeing to the test. Thus, informed consent is necessary.

Now, let's revisit the tPA dilemma. Is tPA routinely administered, and are the indications and potential complications intuitive and common knowledge? The answer is no. If the medical community has continued to debate this concept since the NINDS trial was published in 1995, one must agree that there is sufficient complexity that a reasonable patient cannot be expected to make a reasonable decision about accepting the drug without being appropriately informed. It simply is unethical and unreasonable to consider giving the drug without obtaining informed consent. Recognizing the exposure and liability associated with stroke cases and the non-delivery of tPA, obtaining an informed refusal is recommended for those declining the drug.

Previously, it was noted that the legal concepts of standard of care and consent are related. How so? Any legal duty has a standard of care associated with it, and obtaining consent from patients is no different. A provider must also meet the standard of care when obtaining informed consent. The inability to do so will result in significant liability exposure should a bad outcome occur.

Currently, state statutes are evenly split between the professional standard and the reasonable patient standard. However, recognizing patient autonomy and a focus on patient-centered care may have invoked momentum in favor of the more patient-centric approach. A minority of states have adopted a hybrid approach, using the professional standard but incorporating the requirement to include additional information that the practitioner knows the patient may want. Although the "reasonable professional" or "professional standard," what a reasonable and prudent physician in a similar situation would feel necessary to disclose, is the historical approach, the Canterbury case has given ample notice to all physicians that considering the patient's position is critically important to obtaining informed consent.

Although less case law is available about informed refusal, the same general principles should apply. What is required to obtain informed consent is very likely required to obtain an informed refusal of treatment. The holding in *Cobbs v. Grant* was, "divulge ... all information relevant to a meaningful decisional process." It is no less the prerogative of the client "to determine for himself the direction in which he believes his interests lie," focused on the need to disclose risks beyond the general nature of the procedure.[5,6] The patient consented to abdominal surgery for gastric ulcers but was not informed of any risks. He suffered a splenic injury, underwent splenectomy, and had a very rocky course thereafter. In *Truman v. Thomas*, it was held that a duty exists to inform the patient of the risks of not undergoing the recommended treatment or procedure. In this case, the patient had declined a Pap smear to ultimately

die of cervical cancer at age 30.[5,7]

The importance of obtaining informed consent is taught in medical school, entrenched in traditional medical practice, and enforced by hospital policy. Although the standards of elements of informed consent may not always be correctly applied, the general process is uncommonly omitted altogether. The converse is true for informed refusal. This concept is not routinely represented in medical school curriculums, is not entrenched in medical practice, and is left unaddressed by many hospital standard operating procedures. Furthermore, when refusals are obtained, they frequently do not comport with the doctrine of informed consent. Simply accepting a patient's decision to forego the proposed treatment, test, or procedure, or having the patient sign an against medical advice ("AMA") form, is not adequate. Unfortunately, such practices are common with respect to patient refusals.

In general, the following components should be included in the informed discussion with a patient for consent or refusal of a proposed treatment or procedure: an explanation of the proposed treatment, the risks and benefits associated with the proposed treatment, the anticipated outcomes, and any treatment alternatives, including non-treatment.[8]

Two important concepts deserving adequate treatment with respect to informed consent or refusal are delegation and documentation. The consent or refusal process should be performed by the practitioner who will perform the procedure, and that consent is valid only for that specific practitioner to perform the procedure, unless otherwise disclosed and agreed to by the patient. It is not appropriate to delegate this process to another individual, such as a hospital employee (e.g., a nurse).[9]

Frequently debated is whether or not a consent form is actually necessary. In particular, with respect to patients leaving against medical advice, and refusing a portion or all proposed treatments, is an "AMA" form necessary? In general, consent forms are preferred, as they are a universally accepted standard.[9] To deviate from that standard may call into question whether or not informed consent was actually obtained. However, documentation of the informed consent process in the medical record may be an excellent surrogate for a consent form. What is lacking in many consent forms is a description of the informed consent process. Although a patient has signed the form indicating a particular procedure or treatment has been agreed to, a signature alone does not verify that the consent is valid. In an ideal world, both would be entered into the medical record. However, given the choice of one or the other, documentation of the informed discussion, including the patient's medical decision-making capacity and ability to understand the information provided, has distinct advantages. So, isn't a signature on an "AMA" form enough? A signed refusal of care, without documentation of what the potential consequences of that refusal may entail, is tantamount to no informed refusal at all.

Furthermore, some commentators have reported the concern that "AMA" forms appear adversarial, negatively impacting the physician-patient relationship. Particularly in high-risk patients, avoiding any conflict is advisable from a risk-management perspective.

Medical providers frequently use "AMA" forms to document total refusal of care. However, such documentation is frequently omitted for patients refusing a portion of their care or a particular test, treatment, or procedure. Physicians often overlook the relevance and importance of documenting the patient's refusal of a procedure or of some other significant portion of their care. Finally, a common myth associated with refusals or "AMAs" is that refusal of care will result in denial of coverage by a patient's health insurance carrier, making the patient solely responsible for the charges. This just simply isn't true.

From a practical perspective, a few relevant, actual case examples may help illustrate the concern and appropriate clinical application of the informed refusal process.

Case 1

A 64-year-old male patient presented to emergency department #1 with a headache and neck pain. A CT scan of the brain was obtained and was negative. The physician advised the patient that they should consider the possibility of meningitis, requiring a lumbar puncture to analyze his spinal fluid. The physician stated his suspicion was low for meningitis. The patient stated, "If you are not that concerned, I'm not either." He declined the lumbar puncture. The patient presented to emergency department #2 via ambulance 48

hours later. He was comatose and was diagnosed with a subarachnoid hemorrhage.

Meningitis and subarachnoid hemorrhage may have similar presentations, and both can be diagnosed with lumbar puncture. The informed refusal obtained at hospital #1 was not adequate, as the patient was never informed about the risk of missed subarachnoid hemorrhage. Even if the patient had meningitis, the informed refusal did not include the potential consequences of refusal and the associated lack of identification and early treatment of meningitis.

Case 2

A 49-year-old man presented to the emergency department at 2 a.m. per the insistence of his wife. He had experienced 10 minutes of chest pain. His diagnostic evaluation, including a chest radiograph, laboratory testing, and electrocardiogram (ECG), were normal. Due to his risk factors for coronary artery disease and the characteristics of the pain, the patient was offered admission to the hospital for further investigation. He declined. During the informed refusal process, he stated, "If I'm going to die, I want to do it at home with my boys." His wife was asked to assist with convincing him to consent to admission. Below is the documented refusal note from the medical record.

"The patient was offered admission x 2. He was alert and oriented x 4 and had the capacity to consent and refuse. We discussed the possibility of acute coronary syndrome, the risks of treatment and non-treatment, and the possibility of death. His wife was present and wanted him admitted. She was enlisted to try and convince him."

The patient returned to the same emergency department 24 hours later in the back seat of his wife's car in cardiac arrest. He could not be resuscitated and was pronounced dead.

The patient did not sign an "AMA" form. The documented refusal note included the patient's capacity to refuse, the proposed treatment (admission), the concerns and risks about refusal, and the efforts taken to inform and persuade the patient. Although an incident report was filed for tracking, no claim or lawsuit was ever filed in this case. If an informed refusal had not been obtained and meticulously documented, a different legal outcome may have resulted.

Informed consent and refusal are critical from a risk-management perspective to ensure patients are provided autonomy to make rational health care decisions. Although informed consent has received much more attention than informed refusal, practitioners must realize that case law supports the importance of obtaining and documenting an appropriate informed refusal whenever a patient refuses all care offered or a critical portion of their evaluation or treatment. ■

REFERENCES

1. Furrow BR. *Health Law: Cases, Materials and Problems*, 6th edition. St. Paul: West Publishing; 2008:231.
2. *Schloendorff v. Society of New York Hospital*, 105 N.E. 92 (1914)
3. Sfikas PM. A duty to disclose: Issues to consider in securing informed consent. *J Am Dent Assoc* 2003;134: 1329-1333.
4. Furrow BR. *Health Law: Cases, Materials and Problems*, 6th edition. St. Paul; West Publishing, 2008. Pg 233.
5. Furrow BR. *Health Law: Cases, Materials and Problems*, 6th edition. St. Paul: West Publishing; 2008:243.
6. *Cobbs v. Grant*, 8 Cal. 3d 229, 502 P.2d 1, 104 Cal. Rptr. 505 (Cal. 1972).
7. *Truman v. Thomas*, 611 P.2d 902 (Cal. 1980)
8. Youngberg. *The Risk Manager's Desk Reference*, 2nd edition. Gaithersburg: Aspen Publishing; 1998:190.
9. Furrow BR. *Health Law: Cases, Materials and Problems*, 6th edition. St. Paul: West Publishing; 2008:286.

About to Transfer? Patient's Stability Could Be Issue in Suit

Was a patient transferred without being intubated first because the emergency physician (EP) wasn't comfortable managing a difficult airway? "If the patient requires intubation en route and it doesn't go well, the transferring physician will likely be blamed for not securing the airway prior to transfer — and rightfully so," says **Jeanie Taylor**, RN, BSN, MS, vice president of risk services for

Emergency Physicians Insurance Company in Roseville, CA.

"Patients are usually transferred for services not provided and a higher level of care, but stabilizing procedures such as protecting the airway must be accomplished prior to transfer," she says.

An ED patient might be medically stable, but is he or she stable as defined by the Emergency Medical Treatment and Labor Act (EMTALA)? "The stabilization requirements under EMTALA are confusing to physicians because the concept of medical stability is entirely different than EMTALA stability," says **Stephen A. Frew**, JD, vice president of risk consulting at Johnson Insurance Services and a Rockford, IL-based attorney.

Most EPs consider it inappropriate to transfer an unstable patient, but EMTALA exists to facilitate transfer of legally unstable patients for a higher level of care, Frew explains. "Typically, EPs think of hemodynamic and respiratory stability. They believe that if they have provided ALS [Advanced Life Support] personnel, and equipment, they have addressed the risks, so the patient is stable," he says.

EMTALA considers a patient to be unstable if there is a reasonable risk of material deterioration, says Frew, so the need to provide ALS personnel and equipment is, therefore, confirmation of the legally *unstable* condition of the patient by acknowledging the potential need for these interventions.

The ultimate criteria are whether the inherent risks of the condition and the transfer are outweighed by the benefits reasonably anticipated by transfer to the receiving facility, according to Frew.

"Physicians tend to place their focus on getting the patient moved," he says. "They should be concentrating on a critical analysis of risks and benefits, and the question of, 'What *can* we do for this patient before we transfer them to reduce their risks from and during transport?'"

"It is important to note that where there is no hope for the patient at the sending facility and slim hope at the second, the transfer would still be justified under the EMTALA risk/benefit standard," says Frew. Consider these practices to reduce legal risks involving patients transferred from the ED:

• Call in specialized help early.

"Hospital and ED policies should assure that privilege standards for EPs are high, that skills are verified, and on-call specialists are used liberally to assist in stabilizing and 'packaging' transfer patients," says Frew.

The best way to assure that patients are adequately stabilized for transfer is to call in specialized help early, advises Frew. "While EPs are considered the experts at transfers, they also tend to consider themselves the Lone Ranger when facing a difficult case," he says.

"It is not a failure to have more than one physician stabilizing a patient," underscores Frew. "The EMTALA role of on-call specialists is specifically to back up the EP in these kinds of cases — albeit, they may not always appreciate that role."

EPs in many rural facilities address the lack of reliable backup by resorting to helicopter transfers and relying on the flight crews to appropriately stabilize the patient for transfer, notes Frew. "In too many of those situations, the patient receives little true stabilizing care in the time necessary for the helicopter crew to arrive, making this a very dangerous management approach," he says.

• Don't understate risks of transfer.

EPs tend to consider transfers to be routine or of little risk or consequence, and minimize stated risks, says Frew.

"On the contrary, CMS [the Centers for Medicare & Medicaid Services] states that transfers are never benign events, and looks for disclosures of risks that physicians are uncomfortable bringing up, such as death or disability," he warns.

EPs have typically recognized and considered these risks in making the decision to transfer, and mistakenly feel that they are doing the patient or family a kindness by not discussing ultimate risks, Frew says. "The issue here is that failing to disclose these ultimate risks can nullify the consent and result in an invalid transfer for both EMTALA compliance and liability purposes," he explains.

The reason for transfer should state exactly what service or equipment the patient will get at the receiving hospital that is not available at the sending hospital, Frew advises. "The reason line on a transfer form is often filled in with one or two words, and those words are often very poor choices," he says.

In many cases, the worst case scenario is death or total permanent disability, says Frew, and the risks statement should include these worst case or ultimate risks.

"There are always risks, so never put 'none.' I generally recommend putting at least 'increased pain and discomfort,'" says Frew. "I have seen transfer forms for high-risk OB transfers with risks listed as 'none,' which is ignorant or lazy, or both."

The more a jury can realize from the medical record that the EP was concentrating on the welfare of the patient and understands why the EP made the decisions that he or she did, the more likely they will side with the EP, adds Frew.

"The better the record, the less likely a suit will ever be brought," he says. "The opposite is also true — a bad record or bad attitude will make a suit more likely. Checking boxes on an electronic record or template will not do it. We need a narrative that shows that the EP was involved, caring, and trying."

• Consider policies not as optional, but as "carved in stone" rules that are literally enforced by CMS and often also by the courts.

An EP's deviation from policy based on "professional judgment" is hard to justify, unless there is some specific recognition that there is an allowance for professional judgment or special circumstances, says Frew.

"Avoid language that might forbid the use of reasonable judgment or impose impossible standards," he recommends. "I generally recommend 'weasel words,' as lawyers call them."

For instance, an ED's policy might state, "If, in the medical judgment of the transferring physician, delay for services available at this facility would jeopardize the health or safety of the patient, such determination shall be documented and appropriate transfer effected as expeditiously as possible."

"By inserting the element of medical judgment, CMS or the jury is deprived of an arbitrary rule and must consider the reasonable judgment of the physician in evaluating the appropriateness of transferring without specific care," says Frew. "While this language does not guarantee that CMS or a jury will agree with the decision, the rationale has been accepted in several EMTALA investigations," he underscores. ■

Sources

For more information, contact:

- Stephen A. Frew, JD, Loves Park, IL. Phone: (608) 658-5035. Fax: (815) 654-2162. E-mail: sfrew@medlaw.com.
- John Tafuri, MD, FAAEM, Regional Director, TeamHealth Cleveland (OH) Clinic. Phone: (216) 476-7312. Fax: (440) 835-3412. E-mail: jotafu@ccf.org.
- Jeanie Taylor, RN, BSN, MS, Vice President, Risk Services, Emergency Physicians Insurance Company, Roseville, CA. Phone: (530) 401-8103. Fax: (916) 772-7072. E-mail: jtaylor@epicrrg.com.

Charting This on Transferred Patient Could Deter Lawsuit

If a patient deteriorates because of a transport and later sues, concerns will inevitably arise that the emergency physician (EP) didn't stabilize the patient prior to transport, or that the patient should not have been transferred, says **John Tafuri**, MD, FAAEM, regional director of TeamHealth Cleveland (OH) Clinic and chief of staff at Fairview Hospital, also in Cleveland.

EPs needs to clearly document the reasons for the transfer and why the service couldn't be provided at their hospital, as well as the fact that they did everything possible to stabilize the patient to the best of the capability of the hospital before transfer, advises Tafuri. He recommends these documentation practices:

• If the EP could not get into contact with the consultant and as a consequence had to transfer the patient, the EP should include this information in the patient's chart.

"If stabilization requires a consultant that is at your hospital, that consultant really needs to see the patient prior to transfer," says Tafuri. "This is frequently not known."

If a patient with an unstable orthopedic injury such as a knee dislocation is transferred without seeing the on-call orthopedist, for instance, "there are going to be issues," says

Tafuri. "They will want an answer as to why the orthopedist didn't come in and see the patient."

• If an unstable patient insists on being transferred, the EP should specify that risks involved with the transfer were explained to the patient and the fact that the patient was advised to stay but refused, and was competent to make the decision.

"Plaintiff attorneys don't like cases with patients who refuse treatment. It doesn't play well with the jury," says Tafuri. "I cannot recall seeing a single case involving an unstable patient who insisted on the transfer, except in a situation where the patient was clearly not mentally competent."

EPs should ask an ED nurse to advise the patient to stay as well, and document this attempt in the record, advises Tafuri. "If the nurse couldn't get them to stay either, it's even more difficult for the plaintiff attorney to argue that they both got it wrong," he says.

• If the EP is transferring a patient for insurance reasons, the EP should specify that no meaningful deterioration is anticipated during the transfer, that vital signs are stable and not worsening, and that in the EP's opinion, the patient is stable for transport.

"What you don't want to see is a patient who could otherwise stay at your hospital, with unstable vital signs, who is very tachycardic or hypertensive, and something happens en route," Tafuri says.

• If the patient's vital signs were abnormal at one point in time, the EP should specify that another set of vital signs was taken prior to transfer and they normalized.

"A plaintiff attorney would like to be able to say that the EP last saw the patient at 9:30 and he wasn't transported until 12:30, and the EP doesn't know what happened to him during that time," he says. "Plaintiff attorneys love it when something is overlooked by the physician."

If the EP checks the patient at 8 a.m., for example, and rechecks the patient prior to deciding on a disposition at 9:30 a.m., the transfer might take several hours to occur. During that time, a nurse might chart abnormal vital signs, or the patient's report of dizziness or increasing pain. "That minor entry in the record could be very consequential, and look very bad in retrospect," says Tafuri.

Ideally, the EP should see the patient immediately before transfer and document, "Patient feels well. There are no new complaints." If the attorney sees that the EP rechecked the patient immediately prior to transfer and determined that the patient was stable, it's hard for him or her to argue that the patient never should have been transferred because he or she was unstable, explains Tafuri.

• If an unstable patient is being transferred, the EP should acknowledge this and explain why the transfer is necessary.

If a patient is tachycardic, for instance, the EP should record the vital signs and document, "Patient has tachycardia. However, given the risks and benefits, I feel it is prudent to transfer at this time because these services are not available at the hospital."

"Acknowledge that you know the patient is unstable but that you think the benefits outweigh the risks," says Tafuri. "Show that you are trying to do what is best for the patient." ■

EPs Face Specific Legal Risks if Signing Children Out AMA

Is a parent refusing recommended care for a minor patient in the ED? "Some emergency physicians (EPs) take undue comfort in signing them out against medical advice [AMA]," according to **William M. McDonnell**, MD, JD, associate professor of pediatrics in the Division of Pediatric Emergency Medicine, and adjunct professor of law at University of Utah's S.J. Quinney College of Law in Salt Lake City.

All states have child abuse and neglect reporting laws that require the EP to notify the appropriate state authorities in cases of medical neglect, stresses McDonnell.

"Any time the EP discharges a child despite medical indications to the contrary, there arises some question as to whether the EP should have reported the case to child welfare authorities," he says.

"In many states, the liability for such failure to report includes criminal sanctions against

the physician," says McDonnell. "There are numerous state mandatory reporting statutes that describe failure to report suspected child neglect as a criminal offense."

When the EP is confident that the parental refusal does not rise to the level of reportable neglect, but, rather, simply constitutes a reasonable difference of opinion, the EP should carefully document this in the chart, advises McDonnell.

McDonnell says the language he commonly uses is: "I have discussed the risks and benefits of various treatment options with the parents. Although I have advised them that I believe that XYZ is the best option for this patient at this time, the parents have decided ABC. Although I believe that my recommendation of XYZ is the best option at this time, the parents' medical decision-making of ABC is not unreasonable, and I do not believe that it rises to the level of medical neglect."

"However, if I am unable to say that the parents' decision 'is not unreasonable,' I call child welfare authorities," says McDonnell.

The EP should consider whether the parents are making a decision that they feel is in the best interest of the child, or a decision that is in the parents' own best interest, says **Daniel M. Lindberg**, MD, an attending physician in the Department of Emergency Medicine at Brigham and Women's Hospital and assistant professor of medicine at Harvard Medical School, both in Boston.

"I can reasonably differ with a parent who feels that their child would prefer to take the very low risk of meningitis in order to avoid the certain, small discomfort of a lumbar puncture," he says. "But I don't think the parents have the right to decline a skeletal survey because they are worried that it will reveal abuse and put them in legal jeopardy."

In some situations, a state has concurrent — and sometimes overriding — interests in the care of a minor under the *parens patriae* doctrine, which addresses the right of a court to make decisions on behalf of persons incapable of making them, adds **Michael E. Clark**, JD, LL.M, special counsel at Duane Morris in Houston, TX.[1]

"There are serious liability issues presented when physicians discharge pediatric patients AMA," he says. One such situation involves parents who refuse to provide consent to a medically needed blood transfusion for their child, citing deeply held religious beliefs that require prayer and a reliance on God for healing.[2]

In the face of such a life-threatening situation, the EP should not sign off that the pediatric patient was discharged "AMA," and instead should contact the hospital's attorney, says Clark.

"They can get the necessary authorities involved, such as child protective services and the district attorney's office, so that a court can make the legal determination, which thereby helps to insulate the physician and hospital from liability," he says.

EP in "Tough Bind"

Parental consent is generally required to provide medical care to a child, and when parents choose to leave AMA, they have withheld their consent, says **Douglas S. Diekema**, MD, MPH, an attending physician in the ED at Seattle Children's Hospital.

"This places the physician in a tough bind, and presents two dangers," says Diekema. First, the EP has an obligation to clearly inform the parents that there are risks to leaving and to describe those risks. Second, the EP has an independent obligation to the child, both ethically and legally.

If the EP believes that the parents' decision to leave AMA places the child at significant risk of serious harm, the EP has an obligation under the child neglect laws to report the family to the state's child protection agency, says Diekema.

"Parents should be informed by the physician that they have this obligation under the law, and that they intend to do so if the parent chooses to leave," he advises. If the risk is felt to be significant, serious, and imminent, such as respiratory failure, the EP may need to call the police in order to protect the child.

A signed form may provide some evidence that the parent understood the risks of leaving, but good documentation without a signed form will also serve that purpose, according to Diekema.

"More importantly, neither will get a physician off the hook for failing to report to the state child protection agency if the parent's decision places the child at significant risk of serious harm and the child does, in fact, come to harm," he says.

The best strategy is for the EP to communicate respectfully with families and get them to focus on the welfare of the child, says Diekema, noting that one of the most common reasons families leave an ED is that they get frustrated with how long they have waited.

Good communication about what is happening, what is going to happen, and frequent updates and explanations about wait times can go a long way to keeping a family from getting frustrated, adds Diekema. For instance, an EP might say, "It will take 60 minutes for these labs to come back. In the meantime, we will give your child some fluids through the IV."

"Obviously reducing waiting times helps reduce these kinds of departures," he says. "Ideally, the children who are so sick that leaving AMA would be dangerous, will get seen quickly and have treatment started." ■

REFERENCE

1. Ridgway D. Court-mediated disputes between physicians and families over the medical care of children. *Arch Pediatr Adolesc Med* 2004;158(9):891-896.
2. *O.G. v. Baum*, 790 S.W.2d 839 (Tex.App.—Houston [1st Dist.] 1990).

Sources

For more information, contact:

- Michael E. Clark, JD, LL.M, Special Counsel, Duane Morris, Houston, TX. Phone: (713) 402-3905. E-mail: meclark@duanemorris.com.
- Douglas S. Diekema, MD, MPH, Treuman Katz Center for Pediatric Bioethics, Seattle (WA) Children's Research Institute. Phone: (206) 987-4346. E-mail: diek@u.washington.edu.
- Daniel M. Lindberg, MD, Department of Emergency Medicine, Brigham & Women's Hospital, Boston, MA. Phone: (617) 525-8025. E-mail: dlindberg@partners.org.
- William M. McDonnell, MD, JD, Adjunct Professor of Law, S.J. Quinney College of Law, University of Utah, Salt Lake City. Phone: (801) 587-7450. E-mail: william.mcdonnell@hsc.utah.edu.

Did Colleague Ask for "Curbside Care?"

Most emergency physicians (EPs) would never consider leaving a patient's chart completely blank, as they're well aware of the resulting liability risks, but caring for an ED colleague without documentation is no different, according to **Martin Ogle**, MD, FACEP, senior partner and vice president of CEP America, an Emeryville, CA-based provider of acute care staffing solutions.

EPs might not realize the legal risks involved in writing a prescription for a nurse, technician, or administrative employee who says they have a urinary tract infection, for example. "It's a tough situation to say no to these people when they ask," acknowledges Ogle. "EPs want to help, but are not supposed to be caring for people without going through the appropriate channels."

Depending on the terms of the EP's medical malpractice coverage, if the patient has not been registered as being seen by the EP, coverage might not be triggered in the event of a lawsuit, warns Ogle.

EPs can write off the professional fee if they wish to help their colleague out, but Ogle recommends stating, "I can't just write you a prescription. We have to check you in and I have to document this. We have to make sure we've done this properly."

Ogle is aware of a lawsuit involving an EP who sewed up a laceration on an ED clerical employee who filed a lawsuit after she experienced a delayed rupture of a tendon. She alleged that care was delayed because the EP didn't refer her to a hand specialist. "Fortunately, the hospital was providing malpractice coverage for the EP, so the EP ended up getting coverage. The case was settled," says Ogle.

If the EP has no documentation, there is no way to prove what evaluation was done, what the examination consisted of, or even if any care was provided, says Ogle. "Someone may move on, the relationship isn't there anymore, and sometimes people feel the need to try to get what they can out of a situation," he says. "You really can't take a case like this to trial because you don't have any documentation of what was done. The carrier has to sit down and negotiate a settlement amount."

If a colleague asks for medical care, Ogle recommends that EPs inform the medical director or nurse manager about the situation. "It's not

that the provider is telling on anybody, but it's important to remind people that they can't ask for 'curbside care' from EPs," he says. "You might get away with it 99 times, but it's the 100th time that will get you. It's not the right thing to do." ■

Source

For more information, contact:

- Martin Ogle, MD, FACEP, Vice President, CEP America, Emeryville, CA. Phone: (949) 461-5200. E-mail: MartinOgle@cep.com.

CNE/CME INSTRUCTIONS

HERE ARE THE STEPS YOU NEED TO TAKE TO EARN CREDIT FOR THIS ACTIVITY:

1. Read and study the activity, using the provided references for further research.

2. Log on to **www.cmecity.com** to take a post-test; tests can be taken after each issue or collectively at the end of the semester. *First-time users will have to register on the site using the 8-digit subscriber number printed on their mailing label, invoice, or renewal notice.*

3. Pass the online tests with a score of 100%; you will be allowed to answer the questions as many times as needed to achieve a score of 100%.

4. After successfully completing the last test of the semester, your browser will be automatically directed to the activity evaluation form, which you will submit online.

5. Once the evaluation is received, a credit letter will be sent 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. ■

CNE/CME QUESTIONS

1. Which is true regarding Emergency Medical Treatment and Labor Act (EMTALA) requirements for patients transferred from an ED, according to **Stephen A. Frew**, JD?
   A. Transfer of legally unstable patients for a higher level of care always constitutes an EMTALA violation.
   B. A medically stable patient is also considered to be stable as defined by EMTALA, even if there is a reasonable risk of material deterioration.
   C. The ultimate criteria are whether the inherent risks of the condition and the transfer are outweighed by the benefits reasonably anticipated by transfer to the receiving facility.
2. Which is recommended to reduce liability risks involving disclosing risks of transfer, according to **Stephen A. Frew**, JD?
   A. It is not advisable for EPs to bring up ultimate risks such as death or disability with the family.
   B. Failing to disclose ultimate risks can nullify the consent and result in an invalid transfer.
   C. The reason for transfer should not specify exactly what service or equipment the patient will get at the receiving hospital that is not available at the sending hospital.
   D. It is generally best to list risks of transfer as "none."

3. Which is true regarding pediatric patients who leave the ED against medical advice (AMA), according to **William M. McDonnell**, MD, JD?
   A. All states have child abuse and neglect reporting laws that require the EP to notify the appropriate state authorities in cases of medical neglect.
   B. EPs should never specify in their documentation that they are confident that a parental refusal does not rise to the level of reportable neglect.
   C. The EP cannot be held liable if there is a signed AMA form indicating that the parents understood the risks of leaving.
   D. Without a signed AMA form, even good documentation from the EP can't provide any evidence that the parents understood the risks of leaving.