# 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 LLC


## IN THIS ISSUE




**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: Larry Mellick, MD, MS, FAAP, FACEP, (executive editor) Professor of Emergency Medicine and Pediatrics, Residency Program Director, Department of Emergency Medicine, Medical College of Georgia, Augusta; Theresa Finerty, MS, RN, CNA, BC, (nurse planner) Director, Emergency and Trauma Services, OSF Saint Francis Medical Center, Peoria, IL; Staci Kusterbeck (contributing editor); William Sullivan, DO, JD, FACEP, FCLM, (contributing editor) Director of Emergency Services, St. Mary's Hospital, Streator, IL; Clinical Instructor, Dept. of Emergency Medicine, Midwestern University, Downers Grove, IL; Clinical Assistant Professor, Dept. of Emergency Medicine, University of Illinois, Chicago; Sullivan Law Office, Frankfort, IL; Allison Weaver (Editor) and Lee Landenberger (Associate Publisher). Robert Bitterman, MD, JD, FACEP, (contributing editor) discloses that he is President, Bitterman Health Law Consulting Group, Inc., Charlotte, NC; and he serves on the Board of Governors and committees of the Emergency Physicians Insurance Co., Inc., Auburn, CA.

**MARCH 2007**

**VOL. 17, NO. 3 • (pages 25-36)**


# Halting inappropriate expert witness testimony – Part III: Tort reform to prevent not-so-expert opinions

*by Robert A. Bitterman, MD, JD, FACEP, Contributing Editor*

## Introduction

In the past two months *ED Legal Letter* has explored state medical society actions to rein in unethical or fraudulent testimony by medical experts in malpractice litigation, and the efforts of state medical boards to use their licensure powers to censure, fine, or suspend the medical license of physicians who provide unprofessional testimony.[1,2]

In this last part of the three-part series examining recent cases concerning expert witness testimony, we will look at the effect of state tort reform measures in addressing the expert witness problem. Previous articles discussed methods to attack an unethical expert long after his or her testimony has already harmed a physician defendant. This month we study ways to prevent inappropriate experts from testifying in the first place. The goal of these state reform efforts is to require a plaintiff to convince a 'real' expert, one who has the appropriate credentials and is actually practicing in the same specialty as the defendant, that the treating physician violated the standard of care. These states covet true, actively practicing professional physicians speaking to the jury, not non-practicing professional "testifiers" as expert witnesses.

There are a number of methods used by the states seeking this objective, such as requiring the expert to be board-certified in the same specialty as the defendant physician, requiring to the expert to be actively practicing the same or similar specialty as the defendant, and/or requiring the expert to be familiar with the local community standard of care.

This article highlights two recent cases from Michigan and Texas that demonstrate the effectiveness of the "board certification" and "actively practicing" requirements in preventing unqualified experts from testifying in medical malpractice cases. And finally, for the *coup de grâce* in this series, we report an unusual case in which a U.S. Attorney's office is attempting to put a cardiac surgeon in jail for providing false testimony in a Detroit malpractice case.

## Expert must be board certified in the same specialty as the defendant physician[3]

Plaintiff David Slaggert underwent cardio-thoracic surgery for the replacement of a defective mitral valve and subsequently suffered a stroke and gastrointestinal hemorrhaging requiring additional surgeries. He sued the Michigan Cardiovascular Institute, PC (MCVI), and its employee Luigi Maresca, MD, who was a board-certified cardiovascular surgeon, claiming Dr. Maresca negligently administrated and monitored the anticoagulant Coumadin® postoperatively, causing these complications and the resulting morbidity.[3]

As required by Michigan law,[4] plaintiffs attached to their complaint an affidavit of merit signed by a physician who opined that defendants had failed to properly monitor and adjust plaintiff's postoperative Coumadin® dosage and had also negligently added aspirin to the anticoagulation regimen, resulting in the stroke and internal hemorrhaging. The plaintiff's physician expert was board-certified in internal medicine, but he primarily practiced cardiology.

A plaintiff initiating a medical malpractice action in Michigan must file with the complaint "an affidavit of merit signed by a health professional who the plaintiff's attorney reasonably believes meets the requirement for an expert witness" under state law.[5] If the affidavit is defective, and the time to cure any such defects has passed, then failure to comply with this requirement may lead to total dismissal of the lawsuit.[6] This means that the expert must in fact meet the legal requirements to be an expert witness, or if not, then at least the plaintiff's attorney must have had a reasonable belief that the expert would qualify. Both prongs must be analyzed before the court will toss out the lawsuit for failure to comply with the state's expert witness requirements.

In this case the defendants argued that the plaintiff's expert did not practice in the same specialty as Dr. Maresca, a board-certified thoracic surgeon practicing cardio-thoracic surgery, and therefore, pursuant to Michigan[6] law was not qualified to testify as an expert witness against them.[3]

Plaintiffs argued in response that the administration of anticoagulants following surgery is outside the scope of practice for a thoracic surgeon. They also argued that Dr. Maresca, who no longer actually performed surgical procedures, was not practicing in the field of cardio-thoracic surgery at the time of the alleged malpractice, but rather cardiology.[3] Thus, according to the plaintiffs, the affidavit of merit of a cardiologist was appropriate or, at least, counsel for plaintiff had a reasonable belief that it was appropriate, as required by the statute.[3]

The court noted that the statute governing expert witness testimony provides that if a party against whom testimony is offered in a medical malpractice case is board certified in a specialty, "the expert witness must be a specialist who is board certified in that specialty."[7] The court also noted that in a prior emergency medicine case the Michigan Supreme Court held that the statute "requires that the expert witness 'must be' a specialist who is board certified in the specialty in which the defendant physician is also board certified."[8]

Therefore, the court had no trouble deciding that the plaintiff's expert did not meet the statutory qualifications as an expert witness and thus was ineligible to sign the affidavit of merit necessary for the suit to proceed.[3]

The court also determined that the plaintiff's attorney could not have held a reasonable belief that his cardiology expert would satisfy the state's expert witness rules based on the clear factual circumstances of

***ED Legal Letter™,*** ISSN 1087-7347, is published monthly by AHC Media LLC, 3525 Piedmont Road N.E., Bldg. 6, Suite 400, Atlanta, GA 30305. Periodicals postage paid at Atlanta GA 30304. **POSTMASTER:** Send address changes to ***ED Legal Letter,*** P.O. Box 740059, Atlanta, GA 30374.

**Subscriber Information:** Customer Service: (800) 688-2421. Customer Service E-Mail Address: customerservice@ahcmedia.com. World Wide Web: http://www.ahcmedia.com. Subscription Prices: United States: $499 per year. Multiple Copies: Discounts are available for multiple subscriptions. For pricing information, call Steve Vance at (404) 262-5511. 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 LLC is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

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

Approved by the American College of Emergency Physicians for 18 hours of ACEP Category 1 credit.

AHC Media LLC 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.

Opinions expressed are not necessarily those of this publication, the executive editor, or the editorial board. Mention of products or services does not constitute endorsement. Clinical, legal, tax, and other comments are offered for general guidance only; professional counsel should be sought in specific situations.

**Vice President/Publisher:** Brenda Mooney
**Associate Publisher:** Lee Landenberger
**Contributing Editors:** Robert Bitterman, MD, JD, FACEP, Staci Kusterbeck, William Sullivan, DO, JD, FACEP, FCLM.



AHC Media LLC

**For Customer Service,**
Please call our customer service department at **(800) 688-2421.** For editorial questions or comments, please contact **Lee Landenberger**, Associate Publisher, at lee.landenberger@ahcmedia.com.

the case and because no good faith investigation into the qualifications of the defendant nor any attempt to match those qualifications with an expert for purposes of filing the affidavit of merit with the complaint was made.[3] The plaintiff's attorney must "have had a reasonable belief at the time of filing the instant suit that the proposed expert would meet the qualifications specified by statute."[9]

Consequently, the court found that the affidavit of merit submitted by plaintiffs to be insufficient to initiate their suit and summarily dismissed their claims against the defendants.[3,10]

### Comment

Under Michigan law, the expert must be a specialist who is board certified in the exact same specialty as the defendant.[6] Many states do not require experts to be board certified even if the physician defendant is a board-certified specialist. However, these states do require varying degrees of qualifications before a physician can offer testimony in a malpractice claim.

For example, North Carolina, like Michigan, requires an affidavit of merit to be filed with the malpractice complaint.[11] The affidavit must be signed by a physician who is reasonably expected to qualify as an expert witness under the North Carolina rules of evidence if the case goes to trial; the plaintiffs can't get just any physician to sign the affidavit to initiate the lawsuit.[11] Furthermore, the expert must be willing to testify at trial that the medical care did not comply with the applicable standard of care.[11]

North Carolina, similar to a host of other states such as Georgia, Ohio, and Tennessee, does not require the expert to be board certified in the same specialty as the defendant. Instead, North Carolinian experts must specialize in the same specialty as the defendant or "specialize in a similar specialty which includes within its specialty the performance of the procedure that is the subject of the complaint and have prior experience treating similar patients."[12] The North Carolina courts have held that a testifying physician is a 'specialist' for purposes of this rule if the physician is board certified in that specialty, or holds himself or herself out to be a specialist or limits his practice to that particular specific field of medicine.[13]

Georgia recently enacted new rules on the qualifications of medical malpractice experts which require that the expert witness have "actual professional knowledge and experience in the area of practice or specialty in which the opinion is to be given …"[14]

Ohio has an interesting twist to its expert witness rules. The expert is required to be a physician in the same or substantially similar specialty as the defendant, and if the defendant is board certified, then the plaintiff's expert must be board certified by a board recognized by the American Board of Medical Specialties. However, the expert isn't required to be board certified in the same specialty as the defendant.[15] If the Slaggert case had occurred in Ohio instead of Michigan, the result would have been different.

In Tennessee there is no statutory requirement that the expert witness practice the same specialty as the defendant, but the expert must be licensed to practice a specialty that makes his testimony relevant to the issues in the case and must be sufficiently familiar with the standard of care of the specialist and to give relevant testimony on that subject.[16]

Tennessee also has one very intriguing rule. Its medical expert witnesses must be from the state of Tennessee or a state contiguous to Tennessee.[17] No California or south Florida physicians need apply to provide their expert witness trade in the Volunteer state.[18]

The states should allow testimony only by someone in the same specialty and with the same board certification status as the defendant physician. Why should an endocrinologist be allowed to testify on the management of diabetic ketoacidosis (DKA) in the ED? The endocrinologist knows a great deal more about the disease than the standard of care expected of an emergency physician, and at the same time doesn't practice in an ED to understand the unique circumstances of diagnosing, treating, and managing DKA patients in that environment. It is hardly judgment by one's peers.

### Expert must be actively practicing in the same specialty as the defendant physician[19]

In Texas, when determining whether a physician is qualified by training and experience to testify as an expert in a malpractice case, the court is required by statute to consider, among other things, "whether, at the time the claim arose or at the time the testimony is given, the witness . . . is actively practicing medicine in rendering medical care services relevant to the claim."[20]

Plaintiff Mary Downing presented with an orbital blowout fracture that required surgical repair. She was not exactly pleased with the surgical results, so she sued Dr. Mark Larson for negligence. Her expert witness at trial, who practiced in Arizona, was board certified in plastic and reconstructive surgery, the same as Dr. Larson. However, the expert hadn't personally performed the surgical procedure (which he asserted was negligently performed by Dr. Larson) in well over 15 years.[19]

His explanation of why he hadn't repaired an orbital blowout fracture in 15 years may interest emergency

physicians and explain why hospitals in Arizona don't have any plastic surgeons on call for their emergency departments:

"Like many plastic surgeons, as you progress in practice, you tend to go from reconstructive surgery into cosmetic surgery. And since facial fractures tend to be emergency cases at all hours of the day and night, you get younger associates who come in with you and they do it and that's basically the progression of my practice."[19]

The trial judge decided, since it had been 15 years since the expert had performed surgery like that performed by the defendant, that the expert was not "actively practicing medicine and rendering medical care services relevant to the claim," and excluded the expert's testimony at trial. A divided court of appeals reversed the trial court.[21]

However, the Texas Supreme Court overruled the appellate court and held that the trial court was well within its discretion in determining that the expert was too far removed from surgical practice. In so deciding, the Texas Supreme Court quoted itself, saying:

"We said in *Broders* that expert qualifications should not be too narrowly drawn, but we also said that given the increasingly specialized and technical nature of medicine, there is no validity, if there ever was, to the notion that every licensed medical doctor should be automatically qualified to testify as an expert on every medical question. Such a rule would ignore the modern realities of medical specialization."[22]

## Comment

Very well said, indeed! It is entirely appropriate that physicians be judged by peers who are doing exactly what they are doing on a day-to-day basis.

Many states have some variation of the "actively practicing" rule for medical experts in malpractice cases. In Tennessee, the expert must have practiced in the same specialty at least some time in the year preceding the medical event in question.[23] Georgia requires "active practice of such area of specialty of his or her profession for at least three of the last five years."[14] In North Carolina, the expert witness must have devoted a majority of his or her professional time in the last year to either active clinical practice that includes within that specialty the performance of the treatment at issue, or in the instruction of students in medical school or in residency in the same specialty as the defendant.[24] Texas and a number of states have a similar "teaching" capacity alternative to meet the "actively practicing" requirement to qualify as an expert witness.[20]

Failure of the plaintiffs to tender an expert witness qualified under the state's rules results in dismissal of the case in favor of the physician defendant.[25]

## Federal preemption of state expert witness tort reform

Over the past two decades, the states have painstakingly enacted a variety of malpractice procedural tort reform measures, such as notice provisions, discovery limitations, review panels, statutes of limitation, as well as expert witness rules. All of these protections go out the window, however, if the plaintiff can sue under federal law, specifically Emergency Medical Treatment and Active Labor Act (EMTALA).

EMTALA allows the plaintiffs to "obtain those damages available for personal injury under the law of the State in which the hospital is located …"[26] However, the statute contains a preemption clause, which states that EMTALA preempts any state or local law requirement that directly conflicts with one of its requirements.[27] Thus, the more stringent expert witness qualifications enacted through state tort reform will not apply to cases heard in federal court, where instead the more liberal federal expert witness rules apply.[28]

Thus, the board certification rule of Michigan, the "same specialty" rules of North Carolina, Tennessee, and Georgia, and the "actively practicing" rules of Texas, North Carolina, and Tennessee and all other state expert witness qualifications are not applicable in EMTALA claims. The retired cardiologist from California can testify that the residency trained, board-certified, actively practicing emergency physician in Michigan negligently managed a multiple trauma patient in the ED. So much for considering "the modern realities of medical specialization."

## Summary

Legislating appropriate qualifications and specifications for expert witnesses is an effective means of decreasing the number of inappropriate or unethical experts preying on medical malpractice actions. All states — and the federal courts, too — should require plaintiffs to secure well-trained, equally credentialed, similarly experienced, and currently actively practicing physicians as experts who find merit in the claim before proceeding with litigation against a treating physician.

These last three articles have explored ways to rein in inappropriate, fraudulent, or unethical expert witness testimony. Sanctions by professional societies or declaring testimony as the practice of medicine to allow peer review and licensure actions by state medical boards are some of the other ways, besides legislating expert qualifications, to address the expert witness problem prevalent in medical malpractice litigation today.

But there is at least another way to attack unscrupulous testimony — put the "expert" in jail!

### *Criminal indictment for false medical expert testimony*

In a rare gambit, the U.S. Attorney's office in Detroit is currently prosecuting a Miami cardiovascular surgeon for allegedly lying on the witness stand in a malpractice case.

Dr. Alex Zakharia was criminally indicted by a grand jury in early 2007 for scheming to defraud and obtain money by false pretenses and false representation.[29]

Dr. Zakharia is alleged to have lied on the witness stand in the Motor City about his credentials and experience concerning his practice of coronary bypass surgery. The indictment claims the surgeon buffed the number of his procedures and his responsibilities, asserting that he was the lead surgeon when in fact he merely assisted, in order to boost his credibility in front of the jury and to obtain work as a testifying expert.[29,30] Furthermore, when asked by the plaintiff's attorney — who paid him thousands of dollars for his services — to substantiate his surgical credentials, which defense counsel believed to be grossly exaggerated, the physician is alleged to have misled the attorney so he would continue to be engaged on the case and monetarily compensated.[29]

Ironically, or perhaps not, the very same U.S. Attorney's office had been the defense counsel for the Veteran's hospital and its physicians, which had been sued in the malpractice case that Dr. Zakharia is alleged to have testified falsely.

Now that's going after an unethical expert!

**References**


1. Bitterman RA. Halting Inappropriate Expert Witness Testimony – Part I: Professional Associations Efforts to Police 'Experts'. *ED Legal Letter* 2007;18(1):1-4.
2. Bitterman RA. Halting Inappropriate Expert Witness Testimony – Part II. Efforts of State Medical Boards and State Medical Societies to Police 'Experts'. *ED Legal Letter* 2007;18(2):13-17.
3. *Slaggert v. Michigan Cardiovascular Inst.*, No. 260776 (Mich. Ct. App. July 6, 2006).
4. MCL 600.2912d.
5. MCL 600.2912d(1); MCL 600.2169.
6. MCL 600.2169.
7. MCL 600.2169(1)(a).
8. *Halloran v Bhan*, 683 N.W.2d 129 (Mich. 2004); emphasis added.
9. MCL 600.2169d.
10. See *Geralds v Munson Healthcare*, 259 Mich. App. 225, 233; 673 N.W.2d 792 (2003). Whether such a belief was reasonable is "determined by the circumstances, including the information available to, and the investigation conducted by, the plaintiff's attorney." Also, *Grossman v Brown*, 470 Mich. 593, 599-600; 685 N.W.2d 198 (2004).
11. N.C. Gen. Stat. § 1A-1, Rule 9(j).
12. N.C. Gen. Stat. § 8C-1, Rule 702(b)(1) (2006).
13. *Formyduval v. Bunn,* 138 N.C. App. 381, 530 S.E.2d 96 (2000).
14. OCGA 24-9-67.1(c) (2005).
15. Ohio R.C. 2743.43.
16. Tenn. Code Ann. § 29-26-115 (2006). *Ledford v. Moskowitz*, 742 S.W.2d 645, (Tenn. Ct. App. 1987). *Goodman v. Phythyon*, 803 S.W.2d 697, (Tenn. App. 1990).
17. Tenn. Code Ann. § 29-26-115(b) (2006).
18. *Sutphin v. Platt*, 720 S.W.2d 455, (Tenn. 1986). The requirement that a medical expert witness be a licensed practitioner in Tennessee or a contiguous state does not violate the due process or equal protection rights of a party proffering a medical expert from a non-contiguous state.
19. Tex. Civ. Prac. & Rem. Code Ann. § 74.401(c)(2).
20. *Larson v. Downing*, 197 S.W.3d 303 (Texas 2006).
21. *Downing v. Larson*, 153 S.W.3d 248 (Tex. App. 2004).
22. *Larson v. Downing,* 197 S.W.3d 303 (Texas 2006); quoting *Broders v. Heise,* 924 S.W.2d 148, 152 (Tex. 1996).
23. Tenn. Code Ann. § 29-26-115(b) (2006).
24. N.C. Gen. Stat. § 8C-1, Rule 702(b)(2) (2006).
25. E.g., *Allen v. Carolina Permanente Med. Group*, P.A., 533 S.E.2d 812 (NC. 2000).
26. 42 USC 1395dd(d)(2)(A).
27. 42 USC 1395dd(f).
28. Federal Rules of Evidence (F.R.E.), Rule 702.
29. *U.S. v. Zakharia*, case 2:06-cr-20612, U.S. District Court, ED Michigan, Dec. 1, 2006.
30. See generally McAbee GN. Improper expert medical testimony. *J Leg Medical* 1998;19(2):257-272. Physicians have been criminally prosecuted for improper testimony, usually for perjury. ■


# Avoid violating privacy regs, claims of negligence for patients with STDs

If your patient has a sexually transmitted disease (STD) and you are fearful of him or her infecting others, you may be tempted to inform the patient's spouse or significant other. However, this is the patient's decision to make — not yours.

"If you tell the patient they should discuss this with their husband or wife, and they say no, then under no circumstances can you do so," says **Jonathan D. Lawrence**, MD, JD, FACEP, an emergency department (ED) physician and medical staff risk management liaison at St. Mary Medical Center in Long Beach, CA. "If you spill the beans with the significant other, that's a violation of the law."

However, you can encourage the patient to inform their spouse or sexual partners about their STD. You

*—continued on page 32*

SPECIAL REPORT

# Patients refusing care: Weigh risk vs. autonomy

***by Jay C. Weaver, JD, EMT-P***
*Attorney, Private Practice; Paramedic, Boston Public Health Commission, Boston, MA*

For emergency department (ED) personnel, the most troublesome patients often are those who don't want treatment at all.

Two percent of all people who seek care from an ED leave before optimal care can be rendered.[1] A small number refuse care from the beginning, having been brought to the hospital against their will by law enforcement personnel or prehospital care providers. Regardless of the circumstances under which the patient arrives, a decision to leave the ED against medical advice (AMA) places ED personnel in an awkward predicament, forcing nurses and physicians to choose one of two options: They can allow the patient to leave, or they can restrain him and force him to accept treatment. Like most decisions made in the ED, this one must be made instantly.

Choosing unwisely can have profound legal implications. A physician or nurse who allows a patient to leave prematurely invites a claim of medical malpractice. Conversely, ED personnel who force unwanted treatment on a reluctant patient expose themselves to claims of assault, battery, and even wrongful imprisonment.[2] Because an employer can be held liable for the on-duty actions of its employees, the hospital may be named as a defendant also.

## Patient autonomy

Americans have long enjoyed a right to accept or reject medical care as they see fit. This right flows primarily from the common law, but the Supreme Court has found a constitutional basis for it as well. A handful of jurisdictions, such as Delaware, have granted a statutory right of refusal to their residents. Physicians and nurses cannot force treatment on a patient simply because they believe the patient will benefit from such care. This holds true even when the patient's life hangs in the balance. As the Massachusetts Supreme Judicial Court said in *Harnish v. Children's Hospital*: "Every competent adult has a right to forego treatment, or even cure, if it entails what for him are intolerable consequences or risks, however unwise his sense of values may be in the eyes of the medical profession."[3]

Not all patients have the right to refuse treatment, of course. Minors generally cannot refuse lifesaving care. Nor can individuals who lack the capacity to make rational decisions, or who pose a threat to themselves or others because of mental illness. The duty of ED personnel to provide treatment in the presence of a court order or judicial determination of incompetence is clear. Things become considerably more complex when a normally healthy patient simply decides to leave.

## Patient consent and the 'informed refusal'

In general, treatment cannot begin until the patient has consented to it. To be valid, the consent must be informed — that is, the patient must possess sufficient knowledge about the nature of his condition, the risks and benefits of the proposed treatment, and the risks and benefits of available alternatives to permit a reasoned decision.[4]

Patients cannot expect their physicians to disclose everything they know about the treatment they intend to provide. Not only would most patients have difficulty comprehending such information, but the disclosure process itself would be too cumbersome to permit timely care. Today, some jurisdictions require practitioners to make "those disclosures which a reasonable medical practitioner would make under the same or similar circumstances."[5] Others apply a patient-based standard, requiring the disclosure of facts that a reasonable patient would deem significant in deciding whether to accept the proposed treatment.[6]

Because children are thought to be incapable of making reasoned decisions, patients younger than 18 generally cannot give valid consent. Exceptions are made for "emancipated" minors — individuals younger than 18 who are married, pregnant, living independently, or serving in the military. Increasingly, courts also have recognized the right of "mature minors" to make autonomous health care decisions. Children as young as 8 have been permitted to give consent or refuse care after demonstrating an appreciation of the consequences of their decisions. In the setting of the ED, it is always better to seek consent from the parents or guardians of a minor than to rely on this doctrine, however.

In a true emergency, it is not always necessary to obtain consent. The law has long recognized that legal formalities must take a backseat to the preservation of life and function. In *Jackovach v. Yocom*, the Iowa Supreme Court refused to hold a surgeon liable for acting without parental consent in saving the life of a 17-year-old who had fallen beneath a train.[7] Underlying this decision was concern that physicians would place lives at risk out of concern over liability. Consent to

lifesaving treatment may therefore be presumed in situations where prolonged discussion would seriously jeopardize the patient's welfare, or where the patient cannot give effective consent because he is unconscious, disoriented, or sedated.

A medical emergency does not open the door to whatever treatment a practitioner deems advisable, however. To the contrary, in the absence of consent, a physician or nurse may provide only that care which is necessary to maintain the status quo. Similarly, consent to treatment may not be presumed if the patient previously objected to it. In *Shine v. Vega*, an ED physician incurred liability by sedating and performing endotracheal intubation on an asthmatic who had repeatedly objected to it, and who wanted to leave the ED.[8] The defendant physician learned the hard way that a practitioner may not override a patient's decision simply because the patient's condition deteriorates.

Refusals of care, like consents to treatment, must be informed. ED personnel have an obligation to describe for a departing patient the nature and severity of the patient's condition; the nature, risks, and benefits of the proposed treatment; and the consequences of refusing that treatment. In *Truman v. Thomas,* the defendant physician, Dr. Claude Thomas, saw the plaintiff as a patient for more than five years. At each examination, he suggested a Pap smear, but the plaintiff always refused to have one performed. When the plaintiff developed cervical cancer, she sued Dr. Thomas, claiming that he had been negligent in failing to describe the significance of the test she had repeatedly declined. The California Supreme Court agreed, and upheld the trial court's finding of liability on the part of Dr. Thomas.[9]

When a patient indicates a desire to leave without treatment, ED personnel will be tempted to describe the potential consequences in the broadest possible terms. This may be the easiest approach, but it isn't necessarily the best. Warning a patient that "you might die without treatment" covers every eventuality, but it lacks the specificity needed to be effective. More than one court has held that such a warning is not likely to be taken seriously by patients, and therefore does not operate as a disclosure at all.[10] The same holds true of boilerplate release forms, which talk of risks in general terms and do not put the patient on notice about the risks unique to his or her condition.[11]

A refusal cannot be informed if the patient's condition does not permit him to comprehend the information being provided. Before a patient is allowed to leave, his decision-making capacity must be assessed. Various tests have been devised to guide this process.[12] The more serious a patient's condition is, the more carefully his decision-making capacity should be scrutinized.

## Handling an AMA refusal of care properly

A risk of liability arises with every AMA refusal of care. This risk can be minimized by an ED and its staff, however, through the adoption of certain principles and procedures.

• **A physician should talk with the patient about the risks involved.** In many EDs, nurses obtain the patient's signature on a release-of-liability form as part of the discharge process. There is nothing wrong with this practice. At some point prior to the patient's departure, however, a physician should personally describe the risks involved in the refusal of treatment. Ultimately, it is the physician who must decide whether to allow the patient to leave, and he cannot avoid responsibility by delegating to a resident or nurse the task of disclosing necessary information.

• **Obtain the patient's signature on a form specific to the patient's situation.** By customizing the refusal-of-care form with details about the patient's condition, proposed treatment, and potential consequences of refusal, and by obtaining the patient's signature on this form afterward, the hospital goes a long way toward proving that treatment was not withheld, and that the patient was appropriately informed when he left AMA. If the patient refuses to sign a refusal-of-care form, document the circumstances thoroughly. Quote the patient liberally.

• **Do not allow patients to waive disclosure.** A patient cannot make a knowing waiver of rights unless he knows what rights he is giving up. Patients who not only refuse treatment, but also refuse to participate in a discussion about the consequences, do not make an informed refusal.[13] ED personnel must do everything possible to hold such a discussion, and if the patient absolutely refuses, the interaction should be documented in detail.

• **Communicate and document.** When it becomes clear that a patient intends to leave AMA, the patient's primary care physician should be contacted. The patient should be informed of specific scenarios that should prompt immediate return to the ED, and some kind of followup, whether by telephone or return visit, should be planned. Every aspect of the interaction should be documented. In appropriate circumstances, the refusal-of-care form must expressly state that the patient declined a "medical screening examination" and "stabilizing treatment"; otherwise, the hospital may face severe penalties under the Emergency Medical Treatment and Active Labor Act (EMTALA).

• **Do not appear vindictive.** Behaving angrily in response to the patient's noncompliance has been shown to add to patient resentment, which in turn increases the likelihood of litigation. Reassure the patient that he is free to return to the ED.

**References**


1. Agency for Healthcare Research and Quality. 2006 National Healthcare Disparities Report. Rockville, MD: U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality; December 2006. AHRQ Pub. No. 07-0012.
2. *Schloendorff v. Society of New York Hosp*., 105 N.E. 92, 93 (N.Y. 1914).
3. *Harnish v. Children's Hospital*, 439 N.E.2d 240 (Mass. 1982).
4. *Salgo v. Stanford Univ. Bd. of Trustees,* 317 P.2d 170 (Cal. App. Ct. 1957).
5. *Natanson v. Kline*, 350 P.2d 1093 (Kan. 1960).
6. *Canterbury v. Spence,* 464 F.2d 772 (D.C. Cir. 1972); *Cobbs v. Grant,* 502 P.2d 1 (Cal. 1972).
7. 237 N.W. 444 (Iowa 1931).
8. 709 N.E.2d 58 (Mass. 1999).
9. 611 P.2d 902 (Calif. 1980).
10. See *Wells v. Van Nort*, 125 N.E. 910 (Ohio 1919).
11. See *Bourgeois v. McDonald*, 622 So.2d 684 (La. Ct. App. 1993).
12. Jones RC, Holden T. A guide to assessing decision-making capacity. *Cleve Clin J Med* 2004;71:971-975.
13. See, e.g., Mark Strasser. The right to remain uninformed, 11. *J Med. & Philosophy* 265 (1986). ■


*continued from page 29*

also can — and should — tell the patient that you are required by law to report to the health department any STD that is listed by your state as a reportable disease, and make them aware that the health department may contact their significant other, but that's as far as you can go.

"If you can't convince your patient to tell them, you can't take it upon yourself to go inform the person's contacts," says Lawrence. "You can try to be as convincing as possible, but you can't make the person either get treated or inform their partners."

If you do, you are leaving yourself open for violation of the Health Insurance Portability and Accountability Act, and accusations of negligence, with both criminal and civil liability coming into play, says Lawrence. In essence, you do not have a duty to the patient's spouse — you only have a duty to the patient, he says.

The basic rule is that an STD is like any other medical information — a private matter between the physician and the patient, unless the patient gives permission to disseminate it to anyone else. "Otherwise this information should be shared only with those who by statute require notification," says **Matthew M. Rice,** MD, JD, FACEP, chief medical officer at Northwest Emergency Physicians of TeamHealth in Federal Way, WA.

Other medical professionals may be informed if they are participating in the patient's care and have a need to know, says Rice. Other individuals should not be notified unless there is a compelling reason such as a judicial order, valid legal summons for information, or life-and-death situation. "If the beans are spilled and there are damages, then litigation could successfully occur," says Rice.

Damages from litigation are very case and locality specific, and disclosure of confidential information can invoke financial penalties under federal and possibly state confidentiality laws, says Rice. In civil litigation, a patient's damages are those defined by the litigation process, and most cases would use a negligence claim against the physician which includes the potential award of financial damages including economic or non-economic damages.

When such damages are determined by a jury, they consist of what the jury believes are reasonable damages to the person. "Mental anguish, loss of consortium, potential financial losses from loss of a job or divorce could be considered," says Rice. "Punitive damages, where allowed, may raise the damages even more."

When a patient is diagnosed with an STD, they must also be notified of appropriate medical precautions to take, and reasonable preventive strategies to prevent transmission to others. You should recommend their STD partner be notified and treated, advises Rice. "If the individual is married, then you should tell the patient to notify that party and all others who may be at risk," he says.

Document this provision of information and advice to the patient with as much clarity as possible, recommends Rice. "A witness to the informative process is also helpful. Given such diligence, it is unlikely for a provider to be successfully sued if all best efforts are made to meet the standard of care," he says.

Reporting requirements vary from state to state, and at times, jurisdiction to jurisdiction, but most states and jurisdictions have reporting requirements for gonorrhea, syphilis, and chlamydia. Generally, requirements to report are similar to other infectious diseases with a public health risk. "Thus, each physician should check with their local health departments to see what is required reporting by law," says Rice. "This should also be verified with the hospital where you work, since often a report of an STD comes from

## Key Points

Information about sexually transmitted diseases (STDs) cannot be shared with the patient's spouse or significant other, unless the patient gives you permission.

- You are required by law to report any STD listed by your state as a reportable disease.
- Failing to contact a patient with a positive culture is a significant legal risk for the ED physician and the hospital.
- Ask patients for the best way to reach them, or ask patients to contact you directly.
- "Spilling the beans" is a violation of the law.

a lab report and the ordering physician may not be available."

Typically, hospitals have a systematic process to notify reporting authorities according to statutory law, and a process to notify clinical providers, such as the ED physician, for correlation with a test result and treatment.

"HIV testing has always been more complicated, and the disease has been politicized and carefully regulated for many years," notes Rice. "It would be unusual to know of an HIV positive test without the patient having consented to testing, and strict rules regulate how reporting must be accomplished."

### *Take steps to reach patient*

If you have a positive culture and can't reach the patient, you have to document that you tried and were unsuccessful, says Lawrence. But the question is, how hard do you have to try?

"I don't know of any case where failure to get a hold of the patient ended up being construed as negligent," he says. You must call the patient using the telephone number on record, or send a telegram or letter to the address listed, and if you're unsuccessful because the number is disconnected or information is incorrect, your obligation most likely ends there, says Lawrence.

"If after doing that you still can't get a hold of the patient, you have done all you can do. The standard of care has not yet reached the point where you have to double check that the number is right. You have shielded yourself from liability if you used the contact information on the chart," says Lawrence.

However, you can increase the likelihood that you will be able to reach the patient with this process: Have the nurse or physician personally ask the patient for the best way to reach him or her if the culture comes back positive. "The admitting office often does a terrible job at getting correct phone numbers, and isn't interested in how accurate they are, so their records may not be updated," says Lawrence.

Failure to contact a patient is a significant legal risk for both the ED physician and the hospital, says **W. Frank Peacock,** MD, vice chief of emergency medicine research at The Cleveland (OH) Clinic Foundation. "That is why I rarely establish a callback routine when a patient wants to leave before all their results are back. Instead, I tell the patient they have to contact me," he says. "That way, if there is a failure to reach them for whatever reason, the onus was on them. I've had patients go out to the bar after leaving the ED — how could I possibly track them down?"

At The Cleveland Clinic, for all culture results that may return several days after the patient has left the ED, a callback system is used. When the results come back, the ED physician determines the importance of immediate callback. For example, the patient is called immediately for a positive spinal fluid culture, even if it is 4:00 a.m., but for a positive STD culture, the patient would be called the next morning by an ED nurse.

"Our process requires that the nurse must reach the patient themselves. No message takers or answering machines are allowed," says Peacock.

If an answering machine is encountered, a simple message is left stating that the patient should call the hospital where he or she was treated. When the patient is reached, he or she may be asked to return to the ED or a prescription may be called to a local pharmacy. Appropriate instructions are given, and followup is arranged if needed.

Since patients often leave inadequate or inaccurate information, timely contact is not always possible. However, when a positive test is known and the problem was not already treated, then it is the responsibility of the medical providers and institutions to have worked out a mechanism of informing the patient and public health authorities as required by law, says Rice.

"Prudent medical providers and institutions implement multiple strategies with redundancy, to avoid errors of not notifying individuals of such problems as positive STD tests," says Rice. "Damages from negligence in failing to notify someone of a positive lab test are a very real possibility if litigation occurs."

If calling is not successful, then a first class registered letter to the official listed address is considered reasonable notification, says Rice. "A letter requiring a return receipt is even better," he adds. Another alternative is notifying others listed as responsible parties on medical records, asking them to have the patient con-

## Sources

For more information on privacy and negligence in STD cases, contact:

- **Jonathan D. Lawrence**, MD, JD, FACEP, Emergency Department, St. Mary Medical Center, 1050 Linden Ave., Long Beach, CA 90813. Telephone: (562) 491-9090. E-mail: jonlawrence48@cox.net
- **W. Frank Peacock,** MD, The Cleveland Clinic Foundation, Department of Emergency Medicine, Desk E-19, 9500 Euclid Ave., Cleveland, OH 44195. Telephone: (216) 445-4546. Fax: (216) 445-4552. E-mail: peacocw@ccf.org
- **Matthew M. Rice**, MD, JD, FACEP, Chief Medical Officer, Northwest Emergency Physicians of TeamHealth, 3455 S. 344th Way, Ste. 210, Federal Way, WA 98001. Telephone: (253) 838-6180 ext. 2118. Fax: (253) 838-6418. E-mail: matt_rice@teamhealth.com.

tact a specific office or phone number about medical care issues.

### *Minors and parents*

If a minor is brought to the ED by a parent, and complains of abdominal pain that turns out to be pelvic inflammatory disease (PID), can you inform the parents?

"The law in most states is that most minors can seek care for STDs without their parent's consent. But it doesn't really raise the issue if they are there because the parents brought them," says Lawrence.

In the ED, you will never be 100% certain that the patient has PID, since you won't have cultures back for 48 hours, so you would not be able to tell the parent or the patient definitively that it is an STD, notes Lawrence. "Instead, you can tell them it's an infection and you are investigating the cause," he says.

If a gonorrhea culture comes back positive for a minor who was discharged from the ED, you have every legal right to talk to the parents, and informing them is perfectly acceptable, says Lawrence.

However, he cautions that whenever you are informing people of results over the telephone, you have no foolproof way to verify who they are. "So there are dangers there. You can say, 'We need you to come back to the ED to discuss a lab test result,' which seems a little over-the-top."

As for admitting adolescents with PID, Lawrence recommends obtaining a consultation with a gynecologist to determine whether this is necessary. "That certainly would insulate the ED physician from any accusation that the patient wasn't treated according to the standard of practice," says Lawrence.

Typically, first-time PID is treated as an inpatient to avoid potential litigation, says Rice. "But in some communities, and with new treatment strategies, outpatient treatment may be reasonable if accepted as the community standard," he adds. ■

# Protect personal assets if you're sued for malpractice

If you are an emergency department physician and you are sued, your liability exposure depends on your status with the facility, says **Bryan A. Liang,** MD, PhD, JD, executive director of the Institute of Health Law Studies at California Western School of Law in San Diego, CA and co-director and adjunct associate professor of anesthesiology at University of California-San Diego School of Medicine.

If you are employed by the facility, it is likely that your facility will be the primary target for the lawsuit. "Of course, you personally can be sued as an individual physician as well, but since the facility is the 'deep pocket,' you will likely be secondary as the focus of the lawsuit," Liang explains.

However, if you are an independent contractor, you will likely be personally subject to the lawsuit, says Liang. Although the hospital will also likely be a target, their potential liability is less secure, depending on the state. Some states allow plaintiffs to sue the hospital for the negligence of independent contractors, while others limit the facility's exposure. "But no matter what, if you are an independent contractor, you will be subject to potential liability," says Liang.

## Key Points

If you are sued, you will be subject to personal liability if you are an independent contractor. If you're a hospital employee, the hospital will probably be the primary target, but you may still be individually sued.

- Hire your own attorney to protect your interests.
- Most plaintiffs agree to accept "policy limits only."
- Consult with an asset protection financial counselor.

## Sources

For more information on protecting personal assets, contact:

- **Bryan A. Liang,** MD, PhD, JD, Executive Director and Professor, Institute of Health Law Studies, California Western School of Law, 350 Cedar St., San Diego, CA 92101. Telephone: (619) 515-1568. Fax: (619) 515-1599. E-mail: baliang@alum.mit.edu
- **Linda M. Stimmel**, Stewart Stimmel, 1701 N. Market St., Suite 318, Dallas, TX 75202. Telephone: (214) 752-2648. E-mail: linda@stewartstimmel.com

Generally, malpractice judgments are to compensate the injured party if negligence is found, so depending on the situation, this can be a great deal of money or a limited amount. "It is essential that you have liability insurance and work with your liability insurer for your defense, and get them involved early for strategic purposes," Liang says. "You may want to hire your own attorney as well, to protect your interests beyond allowing the insurance company to control your defense."

There's really no way to avoid personal liability unless you are an employee of a facility, and even then you may be sued in your individual capacity, says Liang. "There have been efforts to try and shield assets, but these generally have not succeeded, and are sometimes looked upon as fraudulent conveyances to avoid payment," he says.

The only legal shield is bankruptcy in some states, which allow certain property exemptions, but this should not be relied upon. "Generally, the risk of suit and liability is a part of emergency department life," says Liang. "The best protection is appropriate care, a good relationship with the patient if possible, and consistent use of patient safety practices in your facility."

The personal risk for a physician if they are sued would be a verdict in an amount over the insurance coverage amount, says **Linda M. Stimmel**, a partner with the Dallas, TX-based law firm of Stewart Stimmel. However, it is rare for a plaintiff to not agree to take "policy limits only" in the event of a verdict over the amount of malpractice insurance coverage, she says.

"Most plaintiffs do not want to take a car, or have to sell a house of a physician. It is far more simple, for example, if a physician has $500,000 coverage and there is a $700,000 verdict, for the parties to reach a settlement and take the $500,000," says Stimmel. "The amount is paid quickly and efficiently."

The physician will usually have to agree to waive an appeal of the verdict and trial. This assures the plaintiff they get some money, whereas an appeal can go on for years with no monies being paid. "A plaintiff can go after a physician for personal liability with a verdict over the insurance amount, but it is uncommon," says Stimmel.

Therefore, one way to avoid personal liability is to have adequate malpractice coverage. Many physicians keep low coverage amounts to lessen their cost, and also under the belief that they will be a "minor target" if there is not much insurance coverage to go after. "That does happen many times, but it is a risk," says Stimmel.

Another way to protect your personal assets in a malpractice case is to seek advice from an asset protection financial counselor. "The physician can seek advice about putting assets in trust to protect the assets in a malpractice case. However, this must be

## 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. ■

## CNE/CME instructions

Physicians and nurses participate in this CE/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. ■

done prior to any lawsuit or claim, since it could be considered fraud if done after being sued," says Stimmel. ■

## CNE/CME *Questions*

9. With whom can you legally share information regarding a patient's sexually transmitted disease?
   A. All persons at risk
   B. All medical professionals even if not involved in the patient's care
   C. Your state health department, if the STD is listed as a reportable disease
   D. Only the patient's spouse

10. Which is recommended to reduce risks when contacting a patient about positive culture results for an STD?
   A. Remember that if the patient's contact information on record at the hospital is incorrect, that is automatically considered as negligence.
   B. Avoid asking patients to contact the ED directly about the results.
   C. Failing to contact a patient does not present any significant liability risks for physicians.
   D. If you can't reach the patient by phone, document your efforts and send a registered letter.

11. Which is accurate regarding personal liability risks and ED malpractice lawsuits?
   A. Even hospital employees may be sued individually.
   B. Independent contractors are not subject to personal liability.
   C. You cannot be personally sued if you are a hospital employee.
   D. Plaintiffs cannot sue hospitals for negligence of independent contractors.

12. Which of the procedures is NOT recommended as a means of minimizing the risk of liability from a patient refusing care against medical advice?
   A. Having a physician talk with the patient about the risks involved
   B. Obtaining the patient's signature on a form specific to the patient's situation
   C. Allowing patients to waive disclosure
   D. Communicating with the patient's personal physician

**Answers:**
9. C
10. D
11. A
12. C