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; Stacey Kusterbeck (contributing editor); John Shufeldt MD, JD, MBA, FACEP, FCLM (contributing editor), Stephanie Rifkinson-Mann, MD, JD (contributing editor), and Suzanne Thatcher (Senior Managing Editor) and Lee Landenberger (Associate Publisher).

NOVEMBER 2007
VOL. 18, NO. 11 • (pages 121-132)

Arbitration of Medical Malpractice Disputes: Part II

Unequal Bargaining Power and Duration of the Agreement

John Shufeldt, MD, JD, MBA, FACEP, FCLM, *Chief Executive Officer, NextCare, Inc., Attending Physician/Vice Chair, Department of Emergency Medicine, St. Joseph's Hospital and Medical Center, Partner, Shufeldt Law Firm*

Unequal Bargaining Power and the Duty of Explanation

In what context would a court determine that a patient was not on equal footing with a provider or institution and, therefore, in a position of weakness regarding his/her ability to effectively bargain?

In *Tunkl*, the defendant hospital asked all new or incoming patients to sign a document entitled, "Conditions of Admission." This document provided that the patient release the hospital from liability for negligent or wrongful acts. The court observed that the "would-be patient is in no position to reject the proffered agreement, to bargain with the hospital, or in lieu of agreement to find another hospital."[1] The court held that the agreement was a contract of adhesion in which the weaker party lacked not only the opportunity to bargain but also any realistic opportunity to look elsewhere for a more favorable contract; the patient must either adhere to the standardized agreement or forego the needed service.[2] In other words, a reasonable person would believe that his/her care was predicated upon the signing of an agreement and that he/she lost his/her right to hold the institution accountable for negligent acts.

In *Wheeler*, a patient who did not know of and was not advised of the existence of the arbitration provision in a hospital's standard printed admission form, which had all the characteristics of a contract of adhesion, was not bound by the agreement.[3] Mr. Wheeler was admitted to the hospital for a cardiac catheterization to diagnose coronary artery disease. Following the test, Wheeler suffered a brain stem infarction that caused "locked-in syndrome" wherein he was only able to communicate with his eyes.

The Wheeler's filed an action against the hospital and the doctors who performed the procedure, seeking damages for the injuries sustained as a result of the defendants' alleged medical malpractice.[4] The hospital filed for an order compelling the plaintiffs to arbitrate their claims.[5] The petition purported that when Mr. Wheeler was admitted

to the hospital, he signed a form entitled "Conditions of Admission" that included a paragraph entitled "Arbitration Option."[6] The next paragraph provided that if the patient does not agree to the "Arbitration Option," he must either place his initials in the space provided on the form or, as an alternative, notify the hospital in writing within 30 days of his discharge of his election not to agree to arbitration. Mr. Wheeler failed to exercise his option *not* to agree to arbitration, neither by placing his initials in the space provided on the admission form nor by notifying the hospital within 30 days of his discharge; the hospital served a written demand for arbitration on all parties to the action.

In resolving the issue, the court began with the basic premise that arbitration is consensual in nature and that the fundamental assumption of arbitration is that it may be invoked "solely by reason of an exercise of choice by [all] parties."[7] The court noted that there "is a strong judicial policy favoring arbitration, [however] there is just as strong a judicial concern regarding the weaker bargaining powers of consumers."[8]

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) 688-2421Customer Service E-Mail Address: customerservice@ahcmedia.com. Editorial E-Mail Address: suzanne.thatcher@ahcmedia.com. World Wide Web: http://www.ahcmedia.com. Subscription Prices: United States: $499 per year. Multiple Copies: Discounts are available for group subscriptions. 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 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.

Senior Vice President/Publisher: Brenda Mooney
Associate Publisher: Lee Landenberger
Senior Managing Editor: Suzanne Thatcher
Contributing Editors: John Shufeldt, MD, JD, MBA, FACEP, FCLM; Stacey Kusterbeck, Stephanie Rifkinson-Mann, MD, JD.

Questions & Comments

Please contact **Suzanne Thatcher,** Senior Managing Editor, at suzanne.thatcher@ahcmedia.com or (404) 262-5514.

The hospital did not dispute that its personnel never called the plaintiffs' attention to the arbitration clause, either before or after his hospitalization, or that the plaintiffs were not provided a copy of the "Conditions of Admission."[9]

Was the agreement enforceable? In *Madden*, the state retirement board, as agent for state employees, entered into an agreement to amend the group health care contract with Kaiser to provide that arbitration would be the sole method of adjudicating malpractice disputes.[10] In light of *Madden's* emphasis on the strong policy favoring arbitration of medical malpractice claims, its pronouncement that arbitration is a "proper and usual" means of resolving such disputes, and its observation that arbitration does not constitute a limitation on the obligations or liabilities of the stronger party, it might be argued that an arbitration clause in a hospital admission form signed by a patient should be enforceable even though the patient was unaware of the provision or its consequences.[11] The court in *Wheeler* opined, "*Madden* does not compel that conclusion in this case."[12] The court distinguished *Madden* by reasoning that "the contract between Mr. Wheeler and the hospital was not arrived at after arduous bargaining between parties of equal strength."[13] The agreement was signed without any discussion with the hospital admitting personnel and, moreover, the patient did not receive a copy of it.[14] The court opined that under these facts, the agreement is closer to the adhesion contract found in *Tunkl* than it is to the negotiated contract in *Madden*.[15] It noted: "As we said at the outset, arbitration is consensual in nature; there must be an agreement to arbitrate 'openly and fairly' entered into."[16] Resolving the ambiguities in favor of the patient, the "Arbitration Option" should not, according to the court, extend to malpractice claims against "any doctor of medicine" without some explanation to the patient at the time he/she signed the admission form of the intended scope of the arbitration provision. The evidence is uncontradicted that no such explanation was given to Mr. Wheeler.[17] Although Mr. Wheeler's care was not predicated upon signing the arbitration agreement, the court determined that he was not aware of the consequences of his signing the agreement and that the hospital's personnel did nothing to enlighten him about the rights he was giving up.

Explanation and Timing of Signature. Does the clinic or hospital staff owe a special duty to the patient to explain what the arbitration agreement means and does the timing of the signature on the form help the court determine whether the contract is unconscionable?

Adequate notice and information. In *Broemmer*, the Arizona Supreme Court refused to enforce a contract to arbitrate because it was presented to the patient as a condition of treatment, contained no explicit waiver of the

right to jury trial, and provided that any arbitrator must be an obstetrician-gynecologist.[18] Broemmer, a high school graduate and without insurance, was age 21, unmarried, and 16 or 17 weeks pregnant. She was escorted into an adjoining room and asked to complete three forms, one of which was the agreement to arbitrate that was at issue in this case.[19] The agreement to arbitrate included language which stated, "any dispute aris[ing] between the parties as a result of the fees and/or services" would be settled by binding arbitration and that "any arbitrators appointed by the AAA (American Arbitration Association) shall be licensed medical doctors who specialize in obstetrics/gynecology."[20] Broemmer completed the forms and clinic staff made no attempt to explain the agreement to her before or after signing it. They also neither had a policy requiring them to explain it, nor did they provide her with copies of the forms.[21]

Observing that under statutes in other states, agreements were subject to requirements designed to insure adequate notice and information to the patient (such as being set forth on a separate sheet of paper and using boldface type) the court opined that the agreement did not insure that the patient knew she was surrendering her right to litigate a malpractice claim before a jury.[22] The court also noted that since the form was given to the patient only a few hours before surgery, it did not afford her reasonable time to reflect on whether she should have revoked the contract after it was executed.[23]

Broemmer returned the next morning for the pregnancy termination procedure, during which she suffered a punctured uterus that required medical treatment. She filed a malpractice complaint approximately one and one-half years after the medical procedure. By the time litigation commenced, she could not recall signing the agreement to arbitrate. The defendant's moved to dismiss, contending that the trial court lacked subject matter jurisdiction because arbitration was required. In opposition, Broemmer submitted affidavits that were uncontested. The trial court considered the affidavits, apparently treated the motion to dismiss as one for summary judgment, and granted summary judgment to the defendants.

On appeal, the appellate court held that the arbitration agreement was a contract of adhesion but that it was not beyond the plaintiff's reasonable expectations and was, therefore, not unconscionable.[24] However, the Arizona Supreme Court overturned and looked beyond the adhesive characteristics of the agreement. The court determined that although the contract was adhesive, that alone did not render it unenforceable. Generally speaking, there are two judicially imposed restrictions on the enforcement of adhesion contracts or provisions thereof.[25] The first is that such a contract or provision that does not fall within the reasonable expectations of the weaker or "adhering" party will not be enforced against him.[26] The second — a theory of equity pertinent to all contracts generally — is that a contract or provision, even if consistent with the rational expectations of the parties, will be denied enforcement if, considered in its context, it is overly oppressive or "unconscionable."[27] The court held that it was beyond Broemmer's reasonable expectations because of her emotional state and the failure to explain to her that the agreement required all disputes, including malpractice disputes, to be heard only by a licensed obstetrician-gynecologist acting as an arbitrator.[28] The court did not evaluate whether the agreement was in fact unconscionable since it determined that it would be unreasonable to enforce such a critical, unnegotiated, and unexplained term against the plaintiff.[29]

Rules to consider. Three distinct rules can be elicited from the aforementioned cases. Patients or their representatives have to be aware of what they are signing. They also have to be educated so that they have the ability to make a clear choice regarding the rights they are agreeing to waive. Lastly, providers cannot immunize themselves from negligence claims by the use of an arbitration agreement.

Duration of the Agreement

Does arbitration need to be re-signed if the parties do not have an ongoing relationship? In an action by a patient against a physician for professional negligence, the trial court determined that the arbitration agreement signed by the patient three years previously did not govern the 1993 treatment that gave rise to the suit because there was not sufficient evidence to support the trial court's finding that there was a continuing physician-patient relationship and, therefore, no expectation of future medical transactions between them.[30]

In *Cochran*, the plaintiff was referred to an orthopedic surgeon for consultation concerning pain in his left ankle stemming from a previous fracture. Prior to treatment, Mr. Cochran signed an arbitration agreement. Dr. Rubens diagnosed Cochran as suffering from posttraumatic degenerative joint disease, discussed the potential need for surgery, but opted to give him an injection of an anti-inflammatory steroid and for follow-up in two weeks. Cochran felt the injection was not helpful; however, he did not want surgery and did not return for his appointment. Cochran's next visit to Dr. Rubens, which ultimately culminated in surgery, was three years later.

Cochran and his wife filed an action in June 1994 alleging Rubens was negligent during Cochran's ankle surgery. Rubens moved to compel arbitration based on the July 1990 arbitration agreement. The court ultimately found the 1990 arbitration agreement was not effective when Rubens performed the surgery in 1993.

In denying Rubens' petition to compel arbitration, the

court impliedly found there was no reasonable expectation of future transactions between the parties after Cochran's 1990 visit to Rubens and, therefore, there was no open-book account between them when Cochran returned to Rubens for evaluation and treatment in 1993.

From this we can determine that if the care is sporadic, not continuous, and, most importantly, that the parties do not expect to have an ongoing relationship, then the agreement, to be effective, must be renegotiated.

What is the rule when a patient returns to his/her provider for the type of care or treatment that brought them to the provider in the first place?[31] The *Gross* court focused on whether there was an ongoing physician-patient relationship because the existence of such a relationship meant the parties expected possible future transactions between them; therefore, the later surgery was a "subsequent open-book account transaction for medical services for which the contract was signed."[32]

In *Gross*, the plaintiff and his spouse filed suit alleging that their primary care physician did not diagnose cancer. *Gross* believed the arbitration agreement was not binding inasmuch as it was only intended to encompass those situations where Gross, "in the course of an ongoing doctor-patient relationship, sought treatment for a condition of the type which initially brought him ... to physician's office."[33] The court disagreed, opining that "there was simply no objective evidence from which a reasonable person could conclude either of the parties viewed their relationship as having terminated."[34]

The *Gross* court focused on whether there was an ongoing physician-patient relationship because the existence of such a relationship meant the parties expected possible future transactions between them; therefore, the later surgery was a "subsequent open-book account transaction for medical services for which the arbitration agreement was signed."[35]

The court reasoned that whether a book account is open or closed is a question of fact. It noted, "while an 'open' book account has been defined as '[a]n account with one or more items unsettled,' it also includes an account with dealings still continuing."[36] By contrast, a "closed" account is, according to *Black's Law Dictionary,* one "to which no further additions can be made on either side ..." Thus, it is clear that the "open" or "closed" nature of a book account turns not on the account balance per se, but on the parties' expectations of possible future transactions between them.[37]

Therefore, it seems logical to conclude that an arbitration agreement, once signed by the parties, covers future care so long as both parties have expectations of an on-going relationship. Without such expectation, an agreement would have to be signed contemporaneously with each patient visit.

Conclusion

Given some of the recent rulings by the Supreme Court, arbitration in the health care arena has become more commonplace. Most states recognize arbitration as a solution that will help relieve crowed court dockets. Also, many providers and hospital systems use arbitration as a method to control risk. Consequently, many hospitals and providers present their patients with arbitration agreements at the initial visit.

Conditions for a valid agreement. Today, there is a strong presumption in favor of arbitration; however, for an agreement to be valid, certain conditions must be met. The agreement can be a contact of adhesion and still be valid provided the patient's treatment is not contingent upon his/her signing the arbitration agreement. Moreover, the patients must be informed, in clear language, what the arbitration agreement means and what effect it has on the patient's ability to litigate. The provider's staff should be available to answer questions and should proactively discuss the terms of the agreement with the patient. The agreement cannot attempt to immunize the provider from negligence claims. The patient should be given a written copy of the agreement to take with them and should not be made to sign during stressful situations. The patient should be given the opportunity to rescind the agreement within 30 days. For every new patient or new treatment plan, the patient should sign a new arbitration agreement. Third parties also may be bound by an arbitration agreement under five distinct theories.

The use of arbitration agreements in the emergency department is problematic at best. Patients can neither be forced to sign nor can their care be contingent upon signing an agreement. However, as arbitration becomes more and more commonplace, providers and institutions must be proactive in educating their patients and the public on the benefits of arbitration for both parties inasmuch as arbitration may offer significant assistance provided that both parties entered into the agreement knowingly and with full disclosure. ■

References

1. *Tunkl v. Regents of University of California,* 60 Cal.2d 92, at 93
2. Id.
3. *Wheeler v. St. Joseph Hospital, et al.,* 63 Cal. App. 3d 345 (App. Dist. 4th 1976)
4. Id. at 349
5. Id. at 350
6. Id.
7. Id. at 355
8. Id.
9. Wheeler at 361
10. *Madden v. Kaiser Foundation Hospitals,* 17 Cal.3d 699, (state retirement board, as agent for state employees, entered into an agreement to amend the group health care contract with Kaiser to provide that arbitration would be the sole method of adjudicating malpractice disputes).

11. Id.
12. Id. at 365
13. Id. at 366
14. Id.
15. Id. at 376
16. Id. at 366
17. Id.
18. *Broemmer v. Abortion Servs. of Phoenix, Ltd.,* 173 Ariz. 148, 149 (Ariz. 1992)
19. Id. at 149
20. Id. at 149
21. Id. at 150
22. Id. at 155
23. Id.
24. Id.
25. Id.
26. Id.
27. Id.
28. Id.
29. Id.
30. *Cochran v. Rubens,* 42 Cal. App. 4th 481 (App. Dist. 4th 1996)
31. *Gross v. Recabaren*, 206 Cal. App. 3d 771 (App. Dist. 2nd 1988)
32. Id. at 778
33. Id. at 777
34. Id.
35. Id.
36. Id.
37. Id.

Are blood alcohol levels needed for intoxicated patients?

Good clinical judgment lowers liability risks

Many ED physicians do not get blood alcohol levels on intoxicated patients because levels do not correlate well with the patient's mental status or competence, while others say this practice is legally risky. So should blood alcohol levels be obtained?

There is no evidence-based answer to this question, says **Robert Shesser,** MD, professor and chair of the department of emergency medicine at George Washington University in Washington, D.C. Many EDs use breathalyzers to get a simple, fast, repeatable quantitative ethanol determination, which doesn't have as much accuracy as a blood determination, says Shesser.

As ethanol is associated with many other medical conditions, and is also seen in patients who have been traumatized, the clinical setting and totality of the patient's evaluation is more important than the actual ethanol level, says Shesser.

Very few clinical indications exist for serum alcohol determinations, but they may be useful in the differential diagnosis of delirium, says **Larry D. Weiss,** MD, JD, professor of emergency medicine at the University of Maryland School of Medicine in Baltimore. For example, if a patient presents with head trauma, apparent alcohol intoxication, and delirium, the serum alcohol level may raise the suspicion of a serious closed head injury.

As a general clinical standard of care, intoxicated patients may be safely discharged when the clinical syndrome of intoxication has resolved, but this does not correlate well with serum alcohol levels, says Weiss. "Evidence and logic does not support drawing serial serum alcohol levels to determine the time of discharge from an emergency department," he says. "A careless plaintiff attorney may allege anything, but an honest expert witness would not claim that serum alcohol levels determine competency to leave an ED."

However, over the course of a career, emergency physicians would accumulate risk if they made disposition decisions based on serum alcohol levels rather than on their clinical judgment regarding the resolution of clinical intoxication, adds Weiss.

Physician should make decision

EDs should not have policies requiring that alcohol levels be obtained in particular circumstances, says Weiss. "Clinical practice should not be dictated by hospital policy, but should be a result of autonomous physician decision making in accordance with national standards of practice," he says.

Not all ED patients will fit into any one policy, says **James Hubler,** MD, JD, assistant clinical professor of emergency medicine at the University of Illinois College of Medicine at Peoria. "And if the ED physician uses his clinical judgment, which may conflict with the policy and there is a bad outcome, then there will be more ammunition for the plaintiff's attorney," says Hubler.

Obtaining an ethanol level is medically important when the diagnosis of ethanol intoxication is in question, says **Tom Scaletta,** MD, FAAEM, chair of the ED at Edward Hospital in Naperville, IL. When the clinical diagnosis of acute intoxication is clear, then levels are not absolutely necessary as long as the patient is steadily improving over time, he says.

"As long as ethanol intoxication was not a misdiagnosis, I think that the legal issues come up more at the point of discharge," says Scaletta.

If the patient has a reliable family member or friend, he or she may be taken home once they are cooperative and able to stand and walk with assistance, says Scaletta. On the other hand, if the patient is leaving on his/her own, the patient must be "functionally" sober. This means that they can walk and talk, will avoid self-injury,

—continued on page 128

SPECIAL REPORT

Discharging from the ED: Did you give proper instructions?

*By **Stephanie Rifkinson-Mann, MD, JD,** Neurosurgical Consultant, Mount Kisco, NY; Attorney, New York City.*

It is the duty of a physician or other health care provider dealing with a case in the ED to give the patient or, in certain circumstances (where the patient's competence is in question), the patient's family, attendants or caregivers, all necessary and proper instructions as to the care and attention to be given to the patient and the cautions to be observed following discharge from the ED. Failure to do so is considered negligence, which will render the health care provider liable for any resulting injury. The duty of care is not limited merely to the diagnosis and treatment of a medical condition, but extends to instructions regarding post-treatment care. The manner in which these instructions are provided may be key to deciding whether or not one may be held liable for negligence.

In *Crawford v. Earl K. Long Memorial Hospital*, the plaintiff, Ella Bennett Crawford, sued for damages resulting from the alleged wrongful death of her son, William Sterling Ross.[1]

Mr. Ross, the decedent, was involved in an altercation during which he was hit on the head with a baseball bat and shot in the shoulder. He was taken by ambulance to Baton Rouge General Hospital, and then transferred to the ED at Earl K. Long Memorial Hospital. The ED physician examined Mr. Ross, and apparently noted no symptoms or signs indicating that he should be admitted for observation or further treatment beyond what he already had received in the ED. The ED physician asked the nursing staff to call Mr. Ross' family to pick him up since he was cleared for discharge, and Nurse Fran Valenti called the plaintiff to come take her son home. After getting Mr. Ross home, the plaintiff went to sleep. The following morning, the plaintiff went to check on her son and found him dead in his bedroom.

The plaintiff filed a lawsuit, alleging that Mr. Ross' death was caused by improper and inadequate diagnosis by the ED physician, and that inadequate treatment and no discharge instructions were provided in the ED. After a trial on the merits, judgment was rendered in favor of the defendants, dismissing plaintiff's suit, and the plaintiff appealed.

The appeals court focused on two issues: 1) whether or not it was an acceptable medical practice at the time to give head injury discharge instructions orally and/or in writing; and 2) whether such instructions actually were given in either form in this particular case. The court reviewed the testimony given in the trial case, noting that objective symptoms referable to head injury were not present at the time the ED physician examined Mr. Ross and that expert testimony indicated that it was appropriate to discharge Mr. Ross home under the supervision of a responsible caretaker. Discharge instructions at the time included waking the patient up at regular intervals over the course of several hours following discharge, questioning him to see if he was alert enough to understand and answer questions, and checking him to see if his pupils were the same size.

Expert testimony during the trial indicated that in 1975, the standard of care was to give discharge instructions to the patient's caretaker orally, rather than in writing. Testimony also indicated that while oral instructions might have been more effective than written instructions, at the time the case was first filed there was a growing trend to provide written discharge instructions; however, this was more as a protective measure to prevent liability.

The second question the court addressed was whether, in fact, discharge instructions were given to the plaintiff, either orally or in writing. The plaintiff alleged that no discharge instruction of any kind was provided. Testimony by the nurse who discharged the decedent to his mother's care indicated that while she specifically spoke to the plaintiff regarding her monitoring the decedent's condition following discharge, she did not recall if she gave the plaintiff written instructions as well. The trial court noted that both principals were so credible that the deciding factor was the insistence of the ED nurse in demanding that the plaintiff come to the hospital to pick her son up, especially since the plaintiff also acknowledged that the nurse was indeed insistent, although for a different reason. The court concluded that,

> It is difficult ... to believe that in view of the emergency room's long standing custom of providing instruction to the relatives of the patients who had suffered head trauma that Ms. Valenti, an experienced nurse, would not have communicated the need for periodic regular awakenings and examinations of the patient. In the final analysis, the court finds that although plaintiff's counsel presented a well prepared case, the plaintiff failed to sustain the burden of proof incumbent upon her.[2]

The appeals court affirmed the lower court's decision, observing

that the ED nurse's insistence that the plaintiff come to the hospital to pick her son up, rather than having the hospital send him home in a taxi as the plaintiff had requested originally, conformed with her contention that the sole reason to have the plaintiff pick her son up was so that the nurse could give her the head injury discharge instructions.

In *Leblanc v. Northern Colfax County Hospital et al,*[3] Lawrence LeBlanc was evaluated by an ED triage nurse for abdominal pain associated with an injury sustained in a fight. She decided that he could be discharged and called the physician on duty, who agreed to see him during regular office hours (four hours later that morning) if his pain continued. However, Mr. LeBlanc did not seek medical attention as directed. He returned to the ED a week later and was hospitalized with acute peritonitis. He died the following day.

The decedent's personal representative, his wife, Evelyn Mastrantoni LeBlanc, filed a malpractice claim against the ED and the hospital. The defendants were Northern Colfax County Hospital and Dr. Floersheim, the ED physician. The trial court had held that while fact issues had been demonstrated as to the negligence of the doctor and the hospital, that negligence did not contribute to the decedent's death because he did not see the doctor as instructed. The trial court granted summary judgment to the defendants and the plaintiff appealed.

The appeals court disagreed with the trial court's holding and focused on the quality of the discharge instructions given the decedent.

The defendant physician testified that the instruction to see a doctor in the morning if the pain continued was adequate, and that it was hospital policy to provide more detailed information to patients only in cases of head injury or the need for a cast. The plaintiff's medical expert had testified that the ED staff should have recognized the risk to the patient and that failure to do so fell below the expected level of care. While the defendant argued that the proximate cause of the man's death was his failure to seek medical attention as instructed, the appeals court noted that "... Given the fact that LeBlanc received instructions consistent with the deficient assessment at the emergency room, a fact finder could find that a patient might delay seeking medical attention ... had the doctor or nurse given instructions which would have alerted a reasonable person to the dangers of not obtaining medical attention, the result here might have been different."[4]

In reversing a summary judgment for the defendants, the court held that a genuine issue of fact existed as to whether the failure to detect a potentially life-threatening situation and the failure to give advice that would apprise the patient of the seriousness of his condition constituted negligence. The case was remanded for a new trial on the merits.

Case law affirms that a doctor has an affirmative duty to provide clear health care instructions to a patient and that the patient must understand them. In *Barnes v. Bovenmeyer,*[5] the court stated that "[i]t is the duty of a physician in charge of a case, to follow the case and to give proper instructions to the patient as to his future acts and conduct."[6] The test for the existence of a doctor's legal duty of care invokes the question of foreseeability (whether an ordinary person in the defendant's position, knowing what the defendant knows or should know, would anticipate that a particular harm was likely to result) and public policy concerns (whether the defendant's negligent conduct should extend to the particular consequences the plaintiff suffered).[7] It is not sufficient to find a defendant liable for negligence unless it can be shown that such negligence was the proximate cause of the injuries suffered by a plaintiff.[8]

Neither *Crawford* nor *LeBlanc* have yet to be overturned, and both continue to be cited in other cases and medical malpractice treatises.[9] Although discharge instructions now largely are given in writing, it should be noted that the converse can occur: that is, that patients and/or their caretakers do not comprehend the written instructions given to them and still require verbal explanations of what they are to do and watch for after leaving the ED. Furthermore, when discharge instructions are given, the patient must be told not just what to do but why he/she must do so. If discharge instructions are not clearly explained, even if the patient and/or caregiver signs the hospital forms indicating their understanding, the ED and its staff still may be held liable for negligent follow-up medical care. ■

References

1. *Crawford v. Earl K. Long Memorial Hosp*., 431 So. 2d 40 (La. Ct. App. 1st Cir. 1983).
2. Id. at 41.
3. *Le Blanc v. Northern Colfax County Hosp. et al.,* 100 N.M. 494, 672 P.2d 667 (NM 1983).
4. Id. at 670
5. *Barnes v. Bovenmeyer,* 255 Iowa 220, 122 N.W. 2d 312 (1963).
6. *Barnes*, at 227. See also *Christy v. Saliterman,* 288 Minn. 144, 167-68, 179 N.W. 2d 288 (1970) (holding that failure to give such instructions is negligence which will render the physician liable for resulting injuries); *Vann v. Harden,* 187 Va. 555, 565, 47 S.E.2d 314 (1948) (holding that the duty of care is not limited to diagnosis and treatment, but extends to instructions).
7. *Murillo v. Seymour Ambulance Assn, Inc.,* 264 Conn. 474, 479, 823 A.2d 1202 (2003).
8. *Monahan v. Weichert,* 82 A.D.2d 102, 106, 442 N.Y.S.2d 295 (1981).
9. 1-8 Medical Malpractice at 8.05 (Crawford); 58 A.L.R.5th 613, sec. 13; 1-18 Harney on Medical Malpractice @ 18.1 (LeBlanc).

continued from page 125

and have a plan of where to go and how to get there. "And if the patient insists on driving home, the blood alcohol level must be under the legal limit," says Scaletta.

When discharging a patient who has been sobering up in the ED, be sure there are no safety concerns, such as the ability of the patient to cross a street or find food or shelter. "If the patient is competent to refuse the blood test or breathalyzer, but may be over the legal limit, I would summon the police who will often make sure the patient does not drive while under the influence of alcohol," says Scaletta.

Lawsuits are prevented with good documentation more so than ethanol levels, says Scaletta. "I am not a fan of policies that dictate clinical care. I prefer that board-certified or emergency medicine residency trained physicians are making these types of decisions on a case-by-case basis."

Sources

For more information, contact:

- **James R. Hubler,** MD, JD, Assistant Clinical Professor of Emergency Medicine at University of Illinois College of Medicine at Peoria, One Illini Drive, Peoria, IL 61605. . E-mail: James.R.Hubler@osfhealthcare.org
- **Edward Monico,** MD, JD, Department of Surgery, Section of Emergency Medicine, Yale University School of Medicine, 464 Congress Avenue, Suite 260, New Haven, CT 06519-1315. Phone: (203) 785-4710. E-mail: edward.monico@yale.edu
- **W. Frank Peacock,** MD, The Cleveland Clinic Foundation, Department of Emergency Medicine, Desk E-19, 9500 Euclid Avenue, Cleveland, OH 44195. Phone: (216) 445-4546. Fax: (216) 445-4552. E-mail: peacocw@ccf.org
- **Tom Scaletta,** MD, FAAEM, Chair, Emergency Department, Edward Hospital, 801 S. Washington, Naperville, IL 60540. Phone: (630) 527-3000. E-mail: TScaletta@aaem.org
- **Robert Shesser,** MD, Professor and Chair, Department of Emergency Medicine George Washington University, 2150 Pennsylvania Avenue Northwest, Washington, DC 20037. Phone: (202) 741-2911. E-mail: rshesser@mfa.gwu.edu
- **Larry D. Weiss,** MD, JD, Department of Emergency Medicine, University of Maryland School of Medicine, 110 S. Paca St, Sixth Floor, Suite 200, Baltimore, MD 21201. E-mail: lweiss@smail.umaryland.edu

Don't miss emergency conditions

The determination of a patient's blood alcohol level has been a two-edged sword in determining physician liability in a claim of medical malpractice, says **Edward Monico,** MD, JD, assistant professor in the section of emergency medicine at Yale University School of Medicine in New Haven, CT. On one hand, levels above the legal limit have bolstered claims of incapacity made by patients who were injured as a result of inadequate monitoring.[1]

On the other hand, when intoxication is assumed without objective proof and patients are injured as a result of a wrongful assumption, the absence of a blood level can work against physicians in malpractice cases, says Monico.[2]

When confronted with a patient who appears intoxicated, keep in mind that your suspicion of limited capacity should be primarily a clinical decision supported by laboratory evidence such as blood alcohol levels, says Monico.

Physician actions, followed by appropriate documentation, should resonate with the clinical and objective determinations of capacity. "For instance, adequate monitoring to prevent injury should be instituted once a patient's capacity is called into question," says Monico. "Also, emergency physicians should seek alternative etiologies for impairment if the clinical suspicion is not supported by the blood alcohol level."

If you fail to get an alcohol level, you could potentially miss a life-threatening problem, warns **Frank Peacock,** MD, vice chief of emergency medicine at The Cleveland (OH) Clinic Foundation. When a patient appears to be intoxicated and the blood alcohol level comes back at 400, that fits—the lab result reflects that the patient is intoxicated, and they should wake up over the next six hours and be fine, says Peacock.

"And as long as that happens, it's okay," says Peacock. "But what is the surprise is when somebody comes in, looks drunk, and the level comes back and it's zero. If you didn't get the level, you wouldn't know that. Then you have a problem. You have a significant legal risk."

Alcohol levels do not correlate with sobriety, notes Peacock. "There are people walking around with a level of 200 who look pretty darn sober. They would still be considered drunk drivers, but that is a different animal," he says. "We are talking about doing the right thing medically. You need to get the level so you know that the altered mental status is because they are drunk."

For example, Peacock believed that one patient was intoxicated, but when the level came back as zero, it was determined that the man was poisoned with antifreeze. "Then we knew he had to go to dialysis, which we arranged and it saved his life—but you wouldn't know that without the alcohol level," says Peacock. ■

References
1. *Scott v. Uljanov,* 74 N.Y.2d 673.
2. *Scott v. Dauterine Hospital Corp.,* 851 So. 2d 1152.

Are you liable for all bad outcomes during a shift?

Chance of legal doctrine holding up is "slim to none"

Imagine being held legally responsible for everything that goes wrong during your shift—whether you were involved or not. Under the "captain of the ship" legal doctrine, could this be a legal reality? Not likely, according to experts in emergency medicine litigation.

The "captain of the ship" doctrine dates back to medical malpractice cases from the 1930s, many involving a sponge left inside a patient during a surgical procedure. The doctrine shifts liability to the surgeon, under the rationale that the surgeon had the authority and responsibility to determine when to exit a particular body cavity, when to close an incision, and when to call for a sponge count.

However, in most jurisdictions, U.S. courts have determined that the "captain of the ship" doctrine is antiquated, says **Jorge A. Martinez,** MD, JD, program director for the combined internal medicine/emergency medicine residency program at Louisiana State University in New Orleans. While hospitals are responsible for the actions or omissions of nurses and paramedics under the theory of *respondeat superior,* ED physicians are not held legally responsible for the actions of others during their shift, he says.

There have been some recent cases where the "captain of the ship" doctrine was successfully used in malpractice suits, but these all involved surgeons in the operating room, not the ED. For example, in a 1987 medical malpractice case, a Colorado court of appeals applied the doctrine against a surgeon sued for wrongful death during an elective surgery.[1]

Though the doctrine is mainly obsolete, this decision shows it is not completely dead, says Martinez. "Apparently, courts may still utilize the doctrine if they conclude that the facts of a situation support a finding that a surgeon 'controlled' a nurse's actions," he says. "It is not impossible that a court could find that in a certain situation, a nurse or paramedic was under the 'control' of an ED physician."

Therefore, a court could conceivably apply the doctrine to a medical malpractice claim where a nurse was negligent in performing acts that were supervised by the ED physician, explains Martinez.

In one recent case, a man was seen by a nurse practitioner in an ED. The nurse practitioner performed a neurological assessment, reviewed X-rays, and determined that the man required analgesics to treat his acute lower back pain.[2] The man was discharged with instructions to follow up with the previously scheduled magnetic resonance imaging (MRI), and an ED physician signed off on the patient's chart.

After the subsequent MRI revealed a spinal cord compression, for which the man required surgery, the man sued the ED physician under the "captain of the ship" doctrine, alleging that the doctor was responsible for the nurse practitioner's negligence in failing to discover the spinal cord compression earlier.[2]

"However, the court held that the doctrine did not apply outside of the surgical arena," says **Blake Delaney,** a health care attorney in the Tampa, FL, office of Buchanan Ingersoll & Rooney.

"Thus, the chance of an emergency department physician who is not a surgeon being held liable as a captain of the ship is slim to none, in my experience."

No patient-physician relationship

If there has been no contact between the ED physician and the patient, there is no patient-physician relationship. Therefore, the patient would have no right of action against the physician, says Martinez.

"Unfortunately, when plaintiff attorneys sue, they usually look at whose name is on the admitting section of the chart and name that physician, whether he or she saw the patient or not," says Martinez. "The physician can get out of it by proving that he or she had no interactions with the patient. Thus, no patient-physician relationship exists."

An exception would be if the physician told the patient to present to the ED so that the physician could evaluate the patient, says Martinez. In that case, a patient-physician relationship would have been instituted by the physician instructing the patient to present to the ED.

A patient-physician relationship would also exist if the ED physician saw the patient and sent the patient

Sources

For more information, contact:
- **Blake J. Delaney,** Buchanan Ingersoll & Rooney, 401 E. Jackson Street, Suite 2500, Tampa, FL 33602-5236. Phone: (813) 222-8137. Fax: (813) 222-8189. E-mail: blake.delaney@bipc.com
- **Jorge Martinez,** MD, JD, Program Director, Internal Medicine/Emergency Medicine Residency Program, Louisiana State University, School of Medicine, 2020 Gravier Street, 7th Floor, Suite D, New Orleans, LA 70112. Phone: (504) 568-3792. Fax: (504) 568-7884. E-mail: JMarti4@lsuhsc.edu

back to the waiting room, or if the ED physician was told about the patient's unstable status, refused to respond to the situation, and failed to check the patient or review the nurses' notes, says Martinez.

Delaney says he is unaware of any situation in which an ED physician would ultimately be held liable for an injury to a patient with whom the ED physician had no involvement, merely because he or she was the "person in charge at the ED."

"That being said, it would not at all be unusual for a patient-plaintiff to sue the ED physician under such a theory, alleging that the ED physician was in charge and that a physician-patient [relationship] was established merely by the patient registering at the ED," says Delaney.

If that happened, the physician would no doubt be subject to deposition and other discovery as a prerequisite to being dismissed from the case, says Delaney. "So even though the ED physician probably would not ultimately be held liable, he or she would be forced to incur attorneys' fees to get out of the suit," says Delaney. "There are several procedures through which such a defendant could then recover his or her attorneys' fees, but those methodologies vary from state to state." ■

References

1. *Krane v. St. Anthony Hospital Systems,* 738 P.2d 75 (Colo Ct. App. 1987.)
2. *Dennis J. Powell v. William Wilson, M.D. et al.* (California Fifth District Court of Appeal, Case No. F049097 (May 23, 2007).

Legal risks significant with "seductive" ED patients

Don't put yourself in a vulnerable position

If a patient is physically violent, your ED's process may involve the use of restraints and contacting security. But the appropriate action to take may be less clear if a patient seems flirtatious, exposes him or herself intentionally, or makes sexually provocative remarks.

"Seductive" patients come in both genders and all ages, says **Dwight W. Scott, Jr.,** an attorney with the health care division of Houston, TX-based McGlinchey Stafford. "Although seduction may imply sexual temptation on its face, in this context it refers to perceived violations of established patient/provider boundaries," he says.

Almost all ED physicians have, at one time or another, cared for a patient who confused the provider's compassion for intimacy, says Scott. "While a majority of these encounters resolve themselves without difficulty, Murphy's Law dictates that some will escalate into major problems," he says.

"Seductive" patients are often volatile, and present significant liability risks to vulnerable and inexperienced ED physicians, says **Matthew Rice,** MD, JD,

United States Postal Service
Statement of Ownership, Management, and Circulation

1. Publication Title	2. Publication No.	3. Filing Date
ED Legal Letter	1 0 8 7 - 7 3 4 7	10/01/07
4. Issue Frequency	5. Number of Issues Published Annually	6. Annual Subscription Price
Monthly	12	$499.00

7. Complete Mailing Address of Known Office of Publication *(Not Printer) (Street, city, county, state, and ZIP+4)*
3525 Piedmont Road, Bldg. 6, Ste. 400, Atlanta, Fulton County, GA 30305
Contact Person: Robin Salet
Telephone: 404/262-5489

8. Complete Mailing Address of Headquarters or General Business Office of Publisher *(Not Printer)*
3525 Piedmont Road, Bldg. 6, Ste. 400, Atlanta, GA 30305

9. Full Names and Complete Mailing Addresses of Publisher, Editor, and Managing Editor *(Do Not Leave Blank)*
Publisher *(Name and Complete Mailing Address)*
Brenda Mooney, 3525 Piedmont Road, Bldg. 6, Ste. 400, Atlanta, GA 30305
Editor *(Name and Complete Mailing Address)*
Suzanne Thatcher, same as above
Managing Editor *(Name and Complete Mailing Address)*
Lee Landenberger, same as above

10. Owner *(Do not leave blank. If the publication is owned by a corporation, give the name and address of the corporation immediately followed by the names and addresses of all stockholders owning or holding 1 percent or more of the total amount of stock. If not owned by a corporation, give the names and addresses of the individual owners. If owned by a partnership or other unincorporated firm, give its name and address as well as those of each individual. If the publication is published by a nonprofit organization, give its name and address.)*

Full Name	Complete Mailing Address
AHC Media LLC	3525 Piedmont Road, Bldg. 6, Ste 400 Atlanta, GA 30305

11. Known Bondholders, Mortgagees, and Other Security Holders Owning or Holding 1 Percent or More of Total Amount of Bonds, Mortgages, or Other Securities. If none, check box → ☐ None

Full Name	Complete Mailing Address
Thompson Publishing Group Inc.	1725 K Street NW, Suite 700 Washington, D.C. 20006

12. Tax Status *(For completion by nonprofit organizations authorized to mail at nonprofit rates.) (Check one)*
The purpose, function, and nonprofit status of this organization and the exempt status for federal income tax purposes:
☐ Has Not Changed During Preceding 12 Months
☐ Has Changed During Preceding 12 Months *(Publisher must submit explanation of change with this statement)*

PS Form **3526**, September 1998 *See instructions on Reverse)*

13. Publication Name: ED Legal Letter
14. Issue Date for Circulation Data Below: September 2007

15. Extent and Nature of Circulation			Average No. of Copies Each Issue During Preceding 12 Months	Actual No. Copies of Single Issue Published Nearest to Filing Date
a. Total No. Copies *(Net Press Run)*			517	700
b. Paid and/or Requested Circulation	(1)	Paid/Requested Outside-County Mail Subscriptions Stated on Form 3541. *(Include advertiser's proof and exchange copies)*	237	229
	(2)	Paid In-County Subscriptions *(Include advertiser's proof and exchange copies)*	4	3
	(3)	Sales Through Dealers and Carriers, Street Vendors, Counter Sales, and Other Non-USPS Paid Distribution	5	6
	(4)	Other Classes Mailed Through the USPS	23	14
c. Total Paid and/or Requested Circulation *(Sum of 15b(1) and 15b(2)*			269	252
d. Free Distribution by Mail *(Samples, Complimentary and Other Free)*	(1)	Outside-County as Stated on Form 3541	17	18
	(2)	In-County as Stated on Form 3541	0	0
	(3)	Other Classes Mailed Through the USPS	0	0
e. Free Distribution Outside the Mail *(Carriers or Other Means)*			32	20
f. Total Free Distribution *(Sum of 15d and 15e)*			49	38
g. Total Distribution *(Sum of 15c and 15f)*			318	290
h. Copies Not Distributed			199	410
i. Total *(Sum of 15g, and h.*			517	700
Percent Paid and/or Requested Circulation *(15c divided by 15g times 100)*			85%	87%

16. Publication of Statement of Ownership
Publication required. Will be printed in the November 2007 issue of this publication. ☐ Publication not required.

17. Signature and Title of Editor, Publisher, Business Manager, or Owner: Publisher — Date: 9/28/07

I certify that all information furnished on this form is true and complete. I understand that anyone who furnishes false or misleading information on this form or who omits material or information requested on the form may be subject to criminal sanctions (including fines and imprisonment) and/or civil sanctions (including multiple damages and civil penalties).

Instructions to Publishers

1. Complete and file one copy of this form with your postmaster annually on or before October 1. Keep a copy of the completed form for your records.
2. In cases where the stockholder or security holder is a trustee, include in items 10 and 11 the name of the person or corporation for whom the trustee is acting. Also include the names and addresses of individuals who are stockholders who own or hold 1 percent or more of the total amount of bonds, mortgages, or other securities of the publishing corporation. In item 11, if none, check the box. Use blank sheets if more space is required.
3. Be sure to furnish all circulation information called for in item 15. Free circulation must be shown in items 15d, e, and f.
4. Item 15h., Copies not Distributed, must include (1) newsstand copies originally stated on Form 3541, and returned to the publisher, (2) estimated returns from news agents, and (3), copies for office use, leftovers, spoiled, and all other copies not distributed.
5. If the publication had Periodicals authorization as a general or requester publication, this Statement of Ownership, Management, and Circulation must be published; it must be printed in any issue in October or if the publication is not published during October, the first issue printed after October.
5. In item 16, indicate date of the issue in which this Statement of Ownership will be published.
6. Item 17 must be signed.

Failure to file or publish a statement of ownership may lead to suspension of second-class authorization.

PS Form **3526**, September 1999 *(Reverse)*

Sources

For more information, contact:

- **Jonathan D. Lawrence,** MD, JD, FACEP, Emergency Department, St. Mary Medical Center, 1050 Linden Ave., Long Beach, CA 90813. Phone: (562) 491-9090. E-mail: jonlawrence48@cox.net
- **Matthew Rice,** MD, JD, FACEP, Northwest Emergency Physicians of TEAMHealth, 505 S. 336th Street, Suite 600, Federal Way, WA 98003. Phone: (800) 336-8614 or (253) 838-6180 ext. 2118. Fax: (253) 838-6418. E-mail: Matt_Rice@teamhealth.com.
- **Dwight W. Scott, Jr.,** McGlinchey Stafford, 1001 McKinney St., Ste 1500, Houston, TX 77002. Phone: (713) 335-2127. Fax: (713) 520-1025. E-mail: dwscott@mcglinchey.com.
- **Jill Panagos,** McGlinchey Stafford, 1001 McKinney St., Ste 1500, Houston, TX 77002. Phone: (713) 335-2133. Fax: (713) 520-1025. E-mail: jpanagos@mcglinchey.com

FACEP, an ED physician with Northwest Emergency Physicians of TEAMHealth in Federal Way, WA.

As with most risk issues, prevention is the key, says Rice. "A physician should never place themselves in a vulnerable position," he says. "Establishing professional boundaries is a must in medicine. This must be learned and reinforced in any ED."

To reduce liability risks of "seductive" patients:

- **Have a chaperone present during examinations.**

Never perform an exam that could be reasonably perceived as sexual by a patient without a chaperone, preferably of the patient's same sex, says Rice. In particular, breast and pelvic exams of women by male doctors and genital exams of men by female physicians should always be chaperoned, he says. "Consider leaving the exam door open if possible on every new patient during the history," adds Rice.

Chaperones should be present for such exams even if the patient and physicians are of the same sex, advises **Jonathan D. Lawrence**, MD, JD, FACEP, an ED physician and medical staff risk management liaison at St. Mary Medical Center in Long Beach, CA. "Though most people think of this scenario as the seductive female with the male doctor, it can be any combination," he says.

- **Ask a chaperone to enter the room if you become uncomfortable.**

When seductive patient behaviors are evident, a physician must rely on colleagues or chaperones for observation of interactions to avoid possible allegations later, emphasizes Rice.

If your "antenna" says a patient is acting strangely, believe what your feelings are telling you, says Lawrence. "Just quietly excuse yourself and get a chaperone," he says. "If the patient makes unfounded accusations later, it's a lot less likely they will be believed if there was a chaperone. Then go about your business and take care of whatever problems the patient has."

Lawrence advises against calling attention to a patient's inappropriate behaviors. "I don't think it's productive to confront the patient, unless you are a psychiatrist and are going to put the patient in long-term therapy to find out why they feel this behavior is necessary," he says.

If the patient does give a false complaint, whether to your department head, hospital administration, or the police, the chart will be reviewed. "If you simply document that a chaperone was present, you've covered the bases and then statements will be taken," Lawrence says. If you have a particularly bad feeling about a patient, you might make additional notes for your own records, adds Lawrence.

Chaperones also can reduce liability risks for the hospital if the patient is creating a "hostile work environment" for ED employees, says **Jill Panagos**, an attorney with McGlinchey Stafford's labor & employment division. "The employer must take proper steps to eliminate the hostile work environment through reasonable remedial action," she says. Remedial action might include having additional staff members present when faced with a troublesome patient, or reassigning staff so that individuals of the same sex or who are otherwise less likely targets of the patient's sexualized behavior care for such a patient.

- **Document the patient's behavior.**

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. ■

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. ■

To provide the best protection from improper claims of professional behavior, document the incident in the patient's medical chart, explaining exactly what the patient did or said and your own response, advises Scott.

If a chaperone is present, clearly document that individual's name, along with a brief comment on the patient's specific behaviors, says Rice. For example, document, "The patient's behavior appeared to me as 'seductive' or 'unusually friendly,' so a chaperone, Nurse X, was immediately asked to enter the room, and the history and physical were completed without any unusual incident occurring."

"Documentation needs to be contemporaneous to the actual incident," says Scott. "Many seemingly harmless incidents escalate due to the provider's failure to document what actually occurred, often out of their own embarrassment of the situation. However, clinicians who fail to adequately document perceived patient misbehavior, for whatever reason, are potentially complicating the subsequent defense of their own personal conduct."

In the ED, physicians don't have the luxury of advance notice of patient encounters prior to presentation, notes Scott. "Therefore, subsequent encounters with a past seductive patient must be dealt with on an ongoing basis," he says. "Past notations within the patient's chart clearly outlining past behavior and how it was dealt with, can help the provider assess the situation and make adjustments as necessary when the patient re-presents."

- **Explain what tests are being done.**

Tell patients what you are doing and why you are doing it so there is no confusion about your professional action, Rice recommends. For instance, tell patients "I am checking for a hernia" in a male exam or "I am feeling for your ovary" in a pelvic exam." It is wise to list the name of a chaperone on a chart when genital or breast exams are completed," says Rice.

- **Consider underlying medical problems.**

Seductive behavior by patients may be an indication of narcissism or borderline personality disorders, notes Rice. "If handled properly and documented properly, this can assist the ED physician in proper patient treatment and referral," he says.

Since inappropriate conduct may be a sign of an underlying psychological issue, emergency physicians must be prepared to seek specialty consults when such behavior warrants additional therapeutic intervention, says Scott. ■

CNE/CME *Questions*

44. If a patient exhibits "seductive" behavior during the ED visit, which is recommended to reduce liability risks?
    A. Avoid chaperones unless the patient's behavior is extreme.
    B. Confront the patient directly.
    C. Quietly excuse yourself and get a chaperone.
    D. Don't document the incident in the patient's chart.

45. Which of the following is recommended to reduce liability risks regarding obtaining blood alcohol levels?
    A. Levels should be obtained whenever the diagnosis of ethanol intoxication is in question.
    B. Policies should specify when blood alcohol levels should be obtained.
    C. Disposition decisions should be based solely on blood alcohol levels.
    D. Intoxicated patients can only be safely discharged when blood alcohol levels are zero.

46. For which scenario would a patient have a legal right of action against an ED physician because a patient-physician relationship existed?
    A. Always, as long as the patient registered at the ED.
    B. If the physician's name is on the admitting section of the chart.
    C. If the ED physician saw the patient and sent the patient back to the waiting room.
    D. Whenever the physician was in charge of other ED staff, even if no contact occurred between the patient and physician.

Answers: 44. C; 45. A; 46. C