

Risk Management Monthly

Emergency Medicine

From The Center for Medical Education, Inc.

PO Box 600, Creamery, PA 19430 -- 800.458.4779 - www.riskmanagementmonthly-emergencymedicine.com

Volume 1, Number 2

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1. Standard of Care

- On any given day, it is defined by any given jury after hearing explanation by expert testimony.
- In malpractice litigation, the "standard of care" may be perceived to be what is stated by "experts" (for both the plaintiff and the defendant), and depends on their individual ability to persuade the jury. (See Section 3 below for more information on expert witnesses.)
 - ✓ Better presentation skills and better "acting" can trump valid science.
- Standards of care are not necessarily defined by textbooks, CME courses, etc.
- Standard of care depends on what is required for a particular situation, *and what a similarly trained and reasonable emergency physician would do in similar circumstances.*
 - ✓ The standard of care can include what a *substantial minority* of qualified physicians would do in similar circumstances.
- Standard of care may also be defined by what is done, per protocol, in your hospital.
- Deviation from the "norm" (a uniform approach) is more likely to be apparent in straightforward cases that are repetitively seen in EDs, when there are no extenuating circumstances.
- The law recognizes that physicians do not all agree on the "proper" approach to a given case.
- The standard of care should not be confused with "standard care" (what *most* physicians would do in a given situation), because what is done by most physicians might not be consistent with good or "evidence-based" care.
 - ✓ For example, routine performance of CT scanning for every child with suspected appendicitis might be a common practice, but should not necessarily be viewed as the "standard of care."
- It is uncertain if "regional" standards of care must meet "national" standards of care. While some might feel that such a requirement would "raise the bar" with regard to the practice of medicine, it must be acknowledged that availability of technology can be an issue and might dictate what is considered to be "reasonable." What is done at the Mayo Clinic at 2:00 in the afternoon may not be the same as what is done in Ispiming, MI, at 2:00 in the morning.

2. Negligence

- First named malpractice case in English law - 1270.
- Elements of negligence include:
 - ✓ The physician has a *duty* to care for the patient
 - ✓ There is a *breach* of that duty on the part of the doctor.
 - ✓ *Harm* is sustained by the patient and is defined by the patient.
 - ✓ The physician's action or inaction was the *proximate cause* of the harm to the patient
- If all four of these elements cannot be linked, malpractice cannot be proven.

3. Who should be an expert witness?

- *Medicine is show business for ugly people* - Success in malpractice cases is all about impressing the jury.
- An expert witness should be a practicing physician from a similar environment and with a similar level of training - not necessarily a "mega-expert" who can address statistics and outcomes but rather a physician who actually practices emergency medicine (although it is preferable that your witness be an "expert" in your field).
- Each state has its own rules regarding the qualifications of an expert witness, and any given judge can decide on any given day who can serve as an "expert" (a weakness of the system).
- Egregious testimony should be challenged. ACEP and AAEM mechanisms will be discussed.
- A "bad" expert chosen by the plaintiff's attorney may actually be favorable to your case. Don't hesitate to advise your attorney if the plaintiff's expert doesn't appear to be qualified or if the testimony given is "bogus."
 - ✓ **Daubert Challenge** - In *Daubert vs. Merrell Dow*, testimony provided by an "expert witness" approved by the judge hearing the case was successfully discounted by the testimony of multiple opposing expert witnesses. Advise your attorney to present a Daubert Challenge if statements presented by an "expert" testifying against you are bogus.
- **"Expert Witness Reaffirmation Statement"** - A program implemented by ACEP in which experts testifying on both sides of a case against an emergency physician affirm that they are willing to have their testimony reviewed by ACEP's Ethics Committee (*see the addendum to this issue of RMM*).
- Both ACEP and the AAEM have addressed the issue of "bad" testimony. The AAEM posts testimony on a website and is developing a listing of "bad experts." In some cases, ACEP has reviewed egregious testimony and issued letters of censure to the involved "experts." Such a letter can essentially end the testifying career of a physician.
- Choosing your own expert to support your case - Work with your attorney to choose a credible expert in the involved matter, with academic credentials specific to the nature of the case. It is preferable to choose an honest physician in practice at the time that the incident occurred, in the area where the incident occurred, who is familiar with the workings of "the system."
- Currently, the U.S. malpractice system consists of a "battle of the experts." In Great Britain, malpractice awards are guided by the testimony of a consultant from the NHS who provides an opinion about whether the care was reasonable or unreasonable.

4. Against Medical Advice (AMA)

- This is actually a legal process of "informed refusal." Getting a patient signature on a form doesn't mean a lot. Some incapacitated patients will sign anything, while other patients will refuse to sign anything. Failure to get a signature doesn't mean that you haven't properly completed the "AMA" process.
- The AMA process relates to several major issues:
 - ✓ The capacity of the patient - Is the patient old enough to make a decision, and capable of understanding the discussion?
 - ✓ What items are necessary to protect yourself from a lawsuit?
- **Cardozo Doctrine** - In a landmark case in 1913 (*Schloendorff vs. Society of New York Hospitals*), Justice Cardozo ruled that "Every human being of adult years and sound mind has a right to determine what shall be done with his own body ... a surgeon who performs an operation without his patient's consent commits an assault for which he is liable in damages."

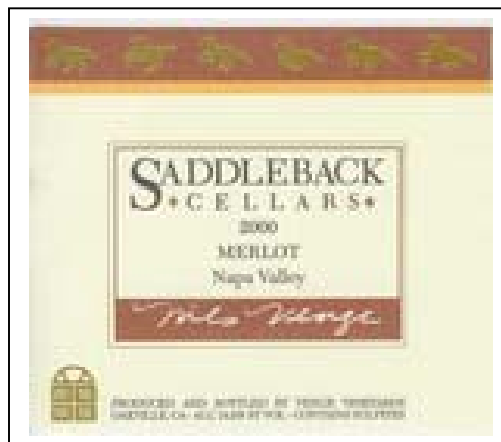
- **Five items to be charted for a valid "AMA"**
 - ✓ The patient is an adult or a declared emancipated minor - When a child is involved and a parent/guardian is not available, the physician acts "in loco parentis."
 - ✓ The patient is of sound mind (has capacity) - You have an obligation to act in the patient's best interests. If there is any indication that the patient's mental status is impaired (e.g., the nurse's note documents slurred speech), the patient should be held in the ED for treatment.
 - You CAN hold the patient "against his/her will" if he/she is functionally impaired.
 - You ARE REQUIRED to hold the patient if he/she is truly incapacitated.
 - You may be LIABLE if you allow an incapacitated patient to leave AMA and he or she sustains an injury....plus there is a responsibility to third parties who might be placed at risk.
 - Determination of capacity does not require a psychiatry consultation. As a physician, you can make a judgment about the patient's ability to understand your discussion and make a reasonable decision.
 - ✓ Inform the patient, in an understandable manner and language, the consequences of nontreatment. Don't use euphemisms (i.e., don't say "You have a dysrhythmia," but rather "You might drop dead"). If there is a reasonable alternative therapy, present it and why it is or isn't appropriate.
 - ✓ Involve family and friends - Often the problem of a patient wanting to leave AMA will be resolved by the patient's family, who recognize the need for treatment.
 - ✓ The signature - The AMA form should include a statement that "leaving against medical advice may result in death or grave disability." Signatures should be obtained from the patient, you (as the physician), the nurse (as your witness), and the patient's family member (if available).
- The great chart will contain documentation of all of these processes as an indication that you have "gone the extra mile" to attempt to provide the patient with proper care.
- The "smart" physician will find a way to keep the patient in the ED. Don't argue with the patient, but give the appearance that you are "on the patient's side."
 - ✓ A good phrase -- If you were a member of my family, this is what I would do for you.
- If you have done all of the above and the patient insists on discharge, you should "part as friends." Provide the patient with needed medications and invite him or her to return if necessary.
 - ✓ You might want to avoid giving pain meds to ameliorate symptoms in a patient with a potentially dangerous condition.
- Insurance companies will not refuse to pay for a visit if the patient leaves AMA. This is an oft-repeated urban myth.
- When the patient does not want to leave AMA, but refuses a needed procedure, the same documentation should take place (i.e., adult status, capacity, discussion, involvement of family members, signatures). Ask the patient what he or she is really worried about with regard to the procedure and attempt to resolve the issue (e.g., sedation for anxiety, analgesia for associated pain, etc.).
 - ✓ Assure the patient that he or she is "the boss" and provide a list of things that should be done.
- Availability of a standardized AMA form can be helpful, listing the necessary elements of "informed refusal" and containing:
 - ✓ The physician's declaration of the patient's competency based on his or her professional judgment.
 - ✓ The patient's acknowledgement (via a signature)
 - ✓ The nurse's acknowledgement
 - ✓ The family member's acknowledgement
 - ✓ The physician's acknowledgement

5. Summary of Major Points

- Standard of care - What a similarly trained emergency physician (and even a substantial minority of same) would do under like or similar circumstances. What a jury decides on any given day, depending on quality of lawyers and experts.
- Negligence - Requires duty on the part of the emergency physician, breach of that duty, harm to the patient, and proximate cause.
- Medical experts - A physician who practices in a similar environment with expertise in the involved condition and who "knows the system" (frequently serves as an expert witness). Some states allow non-emergency physicians to testify against emergency doctors.
- Daubert challenge - Precedent for challenging an expert witness. This federal court doctrine has been utilized by many state courts as well.
- Elements of informed refusal: An adult or emancipated minor, capable of understanding the issues being discussed, who is informed of the potential consequences of nontreatment. Involvement of family and friends if available. Proper signatures (patient, family member, physician, and nurse as the physician's witness).

Wine of the Month

If someone else is paying, you might want to try the 2003 Cabernet Sauvignon by Screaming Eagle (\$500 per bottle -- expensive urine). Saddleback Cellars is a nearby California vinyard....growing similar grapes. At \$36 per bottle, their Merlot is great.



Serving tip -- always start with your best bottle...

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**Addendum to
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ACEP "EXPERT WITNESS REAFFIRMATION STATEMENT"

As a member of the medical profession and the American College of Emergency Physicians (ACEP), I hereby affirm my duty, when giving evidence or testifying as an expert witness, to do so solely in accordance with the merits of the case. Furthermore, I declare that I will uphold the following professional principles in providing expert evidence or expert witness testimony:

1. I will always be truthful, and I will abide by the principles of Ethics of the American College of Emergency Physicians.
2. I will conduct a thorough, fair and impartial review of the facts and the medical care provided, including any and all relevant information.
3. I will provide evidence or testify only in matters in which I have recent clinical experience and knowledge in the areas of medicine that are the subject of the case or proceeding.
4. I will evaluate the medical care provided in light of generally accepted clinical standards, neither condemning performance that falls within generally accepted practice standards nor condoning performance that falls below these standards.
5. I will evaluate the medical care provided in light of the generally accepted standards that prevailed at the time of the occurrence giving rise to the case.
6. I will provide evidence or testimony that is complete, objective, scientifically based, and likely to assist in achieving a just resolution of the proceeding.
7. I will make a clear distinction in my testimony between a departure from accepted practice standards and an untoward outcome.
8. I will make every effort to determine and to specify whether I believe there is a causal relationship between any substandard practice and the medical outcome.
9. I will submit my testimony to peer review, if requested by a professional organization to which I belong.
10. I will not accept compensation that is contingent upon the outcome of the litigation.

Name _____

Signature _____