

# RECENT COURT DECISIONS

By Frank T. Flannery, M.D., J.D.

*The following case summaries highlight recent court decisions that affect medical professionals in diverse health care settings. Topics include non-compliant patients, impaired physicians, and legal requirements of informed consent.*

## **CASE 1**

### **Physician Not Liable For Death Of Non-Compliant Patient**

*Broadie v. St. Francis Hospital (N.Y. Supreme Court, App. Div., 807 N.Y.S. 2d 656, Jan. 31, 2006).*

The 23-year-old decedent suffered from chronic morbid obesity and visited the Emergency Department complaining of swelling of his entire body and dyspnea. Diagnostic tests included an arterial blood gas, which revealed high levels of carbon dioxide, and a chest radiograph. The defendant physician, Dr. Meera Lobo, admitted the decedent to the hospital with a diagnosis of hypoventilation syndrome, among other things,



which often accounts for high carbon dioxide levels in morbidly obese patients. Pneumonia was ruled out.

Immediately after admission, oxygen and a diuretic were prescribed. During his hospitalization, the decedent's oxygenation levels normalized, and signs of possible congestive heart failure resolved. His hospital course was complicated by recalcitrance, in that he

declined to be examined prior to his admission, he “absolutely refused” any medical device to assist ventilation, and he was “totally against” a recommendation that he attend an obesity clinic. He expressly requested to be discharged and to follow-up with his own physician. Three days before his discharge, an echocardiogram revealed a normal left ventricle with only trace amounts of pericardial fluid. No further tests or procedures were recommended by the cardiologist. He was discharged in “fair” condition, as he requested, with home health care arrangements and a prescription for a diuretic.

His recalcitrance continued at home, where he refused to accept oxygen and declined to take his diuretic as prescribed. Moreover, he consumed large amounts of juice and water at home in the days following his discharge. Five days after his discharge, he died at home from congestive heart failure. His autopsy findings included anasarca and 250 cubic centimeters of fluid in his pericardium.

The mother of the decedent brought a wrongful death action, alleging that prior to his death he received negligent care, including negligent failure to remove the pericardial fluid during his hospitalization. Plaintiff’s expert witness testified that the failure to perform a procedure to remove the pericardial fluid was a departure from accepted medical standards, and that this was the proximate cause of his death. The jury ruled in favor of the decedent, finding both the treating physician and the hospital to be negligent. A motion by the defendant doctor and hospital for a judgment notwithstanding the verdict was denied by the trial court.

On appeal, the defendant contended that the evidence presented at trial was totally

insufficient to support the jury’s ruling in favor of the plaintiff. Specifically, the defendant contended that there was no rational process by which the jury could have rendered a verdict against the defendant. The New York Supreme Court, Appellate Division, examined the evidence which had been presented at trial and observed that for the jury to find that the failure to remove pericardial fluid was the proximate cause of death, the jury would have to first draw an inference that the pericardial fluid had accumulated in the three days before the decedent was discharged. This inference by the jury would have been necessary because an echocardiogram three days prior to discharge showed only trace amounts of pericardial fluid.

The appellate court found instead, after a careful examination of the trial testimony, that no evidence in the record existed that would support such an inference. The amount of pericardial fluid discovered during his hospitalization was so small that the cardiologist recommended neither further diagnostic tests nor any medical procedure. In fact, the only conclusion that the appellate court found was supported by the evidence was that the pericardial fluid had accumulated after the decedent’s discharge because of his failure to take his medication and follow his discharge instructions. Moreover, the court found on appeal that no evidence was presented indicating that a premature discharge contributed to the patient’s death. The jury’s verdict was found to be against the weight of the evidence, and the complaint was properly dismissed with no finding of liability on the part of either the doctor or the hospital.

Virtually every treating physician has dealt with noncompliant patients who refuse to follow medical advice and later suffer adverse

consequences. While these patients may present as sympathetic figures and even, as in this case, lead a jury to conclude that their own demise was the result of medical negligence, rather than their own actions, the law demands that any such finding of negligence be objectively supported by concrete evidence to support such a conclusion. Juries are not free to reach results which are totally contrary to the evidence presented. In this case the evidence clearly demonstrated that the decedent refused to both accept medication and oxygen and to follow steps to treat his obesity. The decedent's own conduct was the cause of his demise, and with no legally sufficient evidence to support the jury's conclusion, the plaintiff's complaint was properly dismissed as a matter of law by the appellate court.

An additional point in this case is that the physician carefully documented in the medical records both his recommended medication regimen and follow-up plan, along with notations regarding the patient's non-compliance. This clear medical record documentation conclusively demonstrated that the physician had completely fulfilled his duty to the patient. The appellate court saw ample evidence in the medical record that the patient's demise was not the result of medical negligence, but rather was the result of the patient's own disregard of proper medical advice.

## **CASE 2**

### ***Res Judicata* Doctrine Does Not Bar Suit Against Cardiac Surgeon**

*Vigliotti v. North Shore University Hospital (N.Y. Supreme Court, App. Div., 24 A.D.3d 752, Dec. 27, 2005).*

The plaintiff underwent successful cardiac surgery in 1997 at North Shore University Hospital. Subsequently, he was found to have contracted Hepatitis C. He instituted suit in 1999 against the hospital, alleging that the hospital negligently furnished contaminated units of blood which were administered to him during the surgery, thereby infecting him with Hepatitis C. During the early stages of litigation, the hospital produced proof that all units of blood received by the plaintiff had been tested negative for Hepatitis C. Accordingly, the court was satisfied that the hospital had exercised due diligence, and the plaintiff's case was dismissed with prejudice.

Nine months later, local newspaper accounts contained information regarding a health department investigation which detailed that a cardiac surgeon at North Shore University Hospital was himself infected with Hepatitis C and had transmitted the virus to several of his patients during surgery. The plaintiff conducted his own investigation, and discovered that the physician infected with Hepatitis C, Dr. Michael Hall, was the same cardiac surgeon who had performed his surgery. The plaintiff then instituted a second suit against the hospital again and also Dr. Hall, who had not been included as a defendant in the first suit. The new complaint alleged that both the hospital and the surgeon intentionally and fraudulently concealed Dr. Hall's infected medical status.

The trial court dismissed the second suit, citing the legal doctrine of *res judicata*, a Latin term for "the thing has been judged." Under *res judicata*, a valid judgment by a court precludes future actions between the same parties on the same cause of action. The doctrine precludes "litigation of matters that could or should have been raised in a prior proceeding between the

parties arising from the same factual grouping, transaction, or series of transactions.” Otherwise, endless claims and litigation could potentially result from the same incident.

The plaintiff appealed the trial court’s dismissal of the second suit, arguing that Dr. Hall was not named as a defendant in the first suit, and therefore *res judicata* should not apply. The New York Supreme Court, Appellate Division, heard arguments and reversed the trial court, agreeing with the plaintiff that not only was Dr. Hall not a defendant in the first suit, but also that the second suit was based on a different set of facts. The first suit alleged that contaminated blood, received by the patient during his surgery, was the cause of his infection. The second suit, on the other hand, was premised on a different factual pattern, that is, that Dr. Hall himself was infected and that the hospital had negligently permitted an infected surgeon to operate on the patient without informing him of the risk of contracting Hepatitis C. The claim that the hospital knew or should have known of Dr. Hall’s infected status was, in essence, a new claim, distinct from the prior allegation that the hospital had negligently provided contaminated units of blood for transfusion. This appellate reversal, therefore, allowed the second suit against both the hospital and Dr. Hall to continue.

This case provides an excellent example of the correct application of the legal doctrine of *res judicata*. The doctrine is analogous to the criminal law doctrine of double jeopardy, in which a prior acquittal is conclusive and protects a defendant from being prosecuted over and over again for the same crime. With *res judicata*, a plaintiff is prevented from suing again on a claim that has previously been denied if relitigation would involve issues

previously contested and decided. *Res judicata*, however, will not serve to deprive a plaintiff of the opportunity for legal redress where an alleged wrongdoer was not a defendant in the first action, such as Dr. Hall in this case.

The doctrine also does not apply, again as in this case, where the subsequent litigation involves facts and issues which were not contested in the prior suit. Here, the surgeon’s alleged concealment of his infected status was never an issue in the first case, which dealt only with whether the hospital’s units of blood had been screened for Hepatitis C. When fairly applied, *res judicata* will always protect the integrity of prior judgments involving the same plaintiff and defendant. It will never deprive a plaintiff, however, of the ability to sue a different defendant for the same injury on entirely new legal theories involving new factual situations.

### **CASE 3**

#### **Liability For Impaired Physician’s Failure To Follow-Up Abnormal CT**

*Storms v. Heinss et al. (Whitley County Kentucky Cir. Ct., No. 03-CI-00381, Apr. 27, 2005).*

The 44-year-old patient, Mr. Herman Storms, was employed as an equipment mechanic. He suffered from abdominal pain and was initially seen by his family doctor. When the pain persisted, he was sent to the Emergency Department of Baptist Regional Medical Center on April 4, 2000, where a CT scan was performed. The radiologist read the scan as consistent with probable diverticulitis, but warned of a suspicious lesion on the tail of the patient’s pancreas which would require a repeat

CT. The patient's family doctor was then on vacation, and the patient was seen by a staff gastroenterologist, Dr. John Moore. At the time, Dr. Moore was on probation with the Kentucky Board of Medical Licensure in conjunction with his alcoholism, and was enrolled in the Impaired Physicians Program. The hospital was aware of Dr. Moore's history at the time he was credentialed, and would later argue in the hospital's defense that his credentialing was done in accordance with the requirements of the Impaired Physicians Program.

The patient was admitted to the hospital under the care of Dr. Moore. A day later, the patient was discharged and was never told by the gastroenterologist of the suspicious lesion. Rather, Dr. Moore told him to follow up with his family doctor. Evidence was subsequently presented that on the morning of the patient's discharge, Dr. Moore was in the midst of an alcoholic relapse and in fact had just been released that same morning from the Clay County Jail. Dr. Moore was suspended after these events and subsequently surrendered his medical license.

The patient's symptoms continued and although he saw his family doctor, contradictory evidence was presented regarding whether he was told to have the CT repeated. Two years elapsed, and the patient presented with hematuria and unexplained weight loss. At that time, a CT scan demonstrated pancreatic cancer with metastases to the liver and other organs. He underwent surgery to remove portions of the small intestine, stomach, kidney, and gallbladder, and underwent a lengthy course of chemotherapy at the Mayo Clinic. He died in March, 2005.

The patient's wife sued not only Dr. Moore, the gastroenterologist, but also the hospital that credentialed Dr. Moore and the patient's family doctor. Dr. Moore initially defended the malpractice case, but ultimately settled before trial for a confidential amount. The hospital defended the case, arguing that Dr. Moore's participation in the Impaired Physicians Program should render the hospital blameless. Moreover, according to the hospital, although Dr. Moore had been released from jail on the morning that he visited the patient at the hospital and discharged him, there was no evidence presented that Dr. Moore was intoxicated at the time that he discharged the patient. Likewise, the family doctor denied liability and maintained that during later visits he did in fact instruct the patient to have his scan repeated.

The jury found all three defendants liable, but adjudged that a full 70 percent of the fault belonged to the gastroenterologist, Dr. Moore, while 25 percent belonged to the hospital and just 5 percent belonged to the family doctor. Their total verdict was \$4,776,261.

Malpractice cases involving delay in diagnosis often are precipitated by the failure of medical professionals to properly follow up abnormal studies. In this case, the radiologist's initial reading of a suspicious lesion on the tail of the patient's pancreas, with a recommendation for a repeat CT scan, obviously put the gastroenterologist on notice that follow up was necessary. Instead, no evidence was presented that the gastroenterologist ever communicated this abnormal finding to the patient or ordered further diagnostic testing. Of course, the additional matter of the physician's history of

alcoholism, along with his apparent alcoholic relapse and his release from jail on the very morning that he visited the patient in the hospital and discharged him, made a defense all but impossible. Given the course of events, it is not surprising that the jury found lesser culpability on the part of both the hospital and the family physician. Where failure to properly follow up on an abnormal radiologic study is coupled with impaired physician behavior, as in this case, liability is almost certain. Courts generally hold that adherence to the requisite standard of care requires follow-up of abnormal radiologic studies.

#### **CASE 4**

#### **Jury Finds Adequate Wound Care In Crush Injury**

*Lyons v. Active Medical Group (California Ct. of App., No. G034391, Sept. 28, 2005).*

The plaintiff, John Lyons, sustained injuries on September 8, 2001, when he lost control of the three-wheeled all terrain vehicle he was driving. His right foot was pinned between the vehicle's foot pedal and a tree stump. At the Emergency Department, he was found to have a crush injury with a laceration to the right ankle. Radiologic studies revealed no fracture. The wound was cleaned and sutured, at which time the right ankle was placed in a splint. Keflex was prescribed with instructions to take 250 milligrams four times a day, along with Vicodin for pain. The Emergency Department physician advised the plaintiff to follow up with an orthopedic surgeon for further care.

Two days later, on September 10, the plaintiff visited Dr. Aziz Awad for wound care, and he

returned again on September 14 and 19 as well. On September 19, Dr. Awad himself prescribed Keflex at a dose of 250 milligrams twice a day, which was a lower daily dose than had been prescribed at the Emergency Department.

On October 5, the plaintiff returned to the Emergency Department, complaining of swelling, wound drainage and pain. There, the sutures were removed and Keflex was now prescribed at a dose of 500 milligrams four times a day. He returned to the Emergency Department on October 9, and was found to be improved, but finally returned again on October 23, at which time he was admitted to the hospital. An MRI revealed osteomyelitis, and a wound culture yielded organisms in part resistant to Keflex. After a nine day hospitalization, he was discharged. He later was diagnosed with osteopenia and complex regional pain syndrome with reflex sympathetic dystrophy, and he received seven spinal blocks to alleviate chronic pain. He stated he was unable to work at his prior position in the construction industry and he brought suit against Dr. Awad and the Active Medical Group, alleging that negligent wound care by medical professionals had resulted in the osteomyelitis.

At trial, the plaintiff produced a family practitioner as an expert witness, who testified that Dr. Awad's failure to remove the sutures within 14 days fell below the standard of care, as did his prescribing a "subtherapeutic dose" of Keflex at 250 milligrams twice a day. Another plaintiff's expert was a specialist in Infectious Disease, and likewise testified that Dr. Awad "under dosed" the patient with Keflex. Additionally, he testified that "sutures need to come out at a certain point, certainly ten

days is usually the max.” According to the plaintiff’s expert, poor wound care caused the osteomyelitis to develop.

Dr. Awad testified that he himself performed a thorough, comprehensive examination of the patient on September 10 and at all subsequent visits, to include careful assessment of the limb’s neurological function. When informed by the patient that the radiologic studies at the Emergency Department were negative, he then ordered the report for himself in order to confirm the information. Dr. Awad instructed the patient to rest and elevate the limb, with frequent follow up care. At no time did the wound appear infected, according to Dr. Awad. As for his prescribing Keflex at a dosage of 250 milligrams twice a day, he testified that was “appropriate prophylaxis for [a] non-infected wound.” With regard to leaving the sutures in place, he argued that “sutures are normally removed within 10 to 14 days,” but in certain cases such as this, leaving them in place for up to three or four weeks along with prophylactic antibiotics can be less risky.

The defendant’s expert was an orthopedic surgeon who had completed a one-year fellowship in sports medicine with emphasis on foot, ankle, knee, and shoulder care. He had additionally spent three months in training with another orthopedic specialist treating ballerinas and performing foot and ankle surgeries on members of the New York Ballet. He testified that he had practiced for 11 years, and that he performed about 30 ankle surgeries per month. In his view, the defendant’s wound care was entirely appropriate. Reviewing Dr. Awad’s medical record entries, he testified that the wound was appropriately assessed and cleaned at all follow-up visits. As for Dr. Awad’s use of Keflex at a dose of 250 milligrams twice a day,

he testified that it was appropriate as “the most cost effective medication,” and the dosage was entirely appropriate for “prophylactic treatment.” Regarding the issue of failing to remove the sutures at ten days, this orthopedic expert testified that in his view sutures should remain in place for “at least two weeks. And the average is about three weeks, because if you take them out too early, then the wound may open up and you have a lot more complications.” He found the wound care in all respects to be entirely appropriate.

The jury deliberated and eventually found in favor of the defendants and the plaintiff then appealed, contending that the jury’s verdict was not supported by the evidence. Specifically, the plaintiff claimed on appeal that the expert witnesses conclusively proved that Dr. Awad had breached the standard of care. The California Court of Appeal considered the plaintiff’s argument, but rejected it and upheld the trial court’s verdict in favor of the defendants. According to the appellate court, they must apply the “substantial evidence rule” on appeal when the trial court’s verdict is attacked for insufficiency of evidence. Under this rule, the appellate court must determine “whether there is any substantial evidence to support the findings.” All the evidence presented that was most favorable to the defendant, in this case, must be accepted by the appellate court as true, in order to judge whether sufficient evidence existed to support the jury’s verdict. In this case, it was found that although conflicting testimony was presented, sufficient evidence existed for the jury to rule in favor of the defendant physician and clinic.

While this case deals with the relatively mundane matter of proper wound care, it nonetheless illustrates an important legal

principle. Some litigants erroneously believe that a legal appeal of a trial court's decision gives them a brand new "second chance" to prevail. In fact, appellate courts do not "retry" cases, and they are not free to reverse a jury verdict on appeal because the conflicting testimony could have supported an opposite result. The parameters of their review are rather circumscribed. When an unsuccessful plaintiff, as in this case, alleges that the jury's verdict is not supported by evidence, appellate courts must apply the "substantial evidence" rule and decide if evidence was presented which, if accepted by the jury, could have supported their verdict. The jury's role at trial is to weigh the evidence, to consider witness credibility, and to resolve evidentiary conflicts, and the appellate court cannot substitute its own judgment for that of the jurors who had the advantage of personally hearing all the testimony. If sufficient evidence was presented to enable the jury to support their verdict, the appellate court must uphold the verdict under the substantial evidence rule.

This case illustrates several secondary points as well. One such point is that adverse clinical results, in and of themselves, do not bespeak negligence. In other words, despite adequate care, bad results sometimes occur, but liability can only be found where adverse consequences result from negligent care. Osteomyelitis, for example, can occur with superior wound care, and in the absence of negligent care, liability cannot be supported.

Another point is that adequate medical care can at times encompass a spectrum of acceptable treatment modalities. As in this case, several medical practitioners can express different opinions as to the proper management of lacerations. While reasonable practice for some

may ordinarily involve suture removal at ten days, other practitioners may convincingly argue that leaving sutures in place for two to three weeks under certain circumstances is entirely appropriate. As physicians all know, medicine is not an exact science, and while generally accepted guidelines are useful, individual cases may call for reasonable alternate approaches depending upon the circumstances. There can be no rigid, "cookbook" approach to determining the standard of care.

## **CASE 5**

### **Informed Consent Does Not Require Surgeon To Disclose Statistical Success Rate**

*Wlosinski v. Cohn* (269 Mich. App. 303, Dec. 20, 2005).

Michael Wrobel, a high school senior, presented in May 1998 with kidney failure. His mother, after testing, was deemed to be a suitable kidney donor, and the family researched various hospitals, discovering that William Beaumont Hospital had a high success rate for kidney transplants, according to posted reports on a national organization website. They visited the hospital and met with the defendant surgeon, Dr. Steven Cohn, who explained the transplant procedure. According to the plaintiff, Dr. Cohn represented that his history of transplant success was "good," but he offered no specific statistics.

Dr. Cohn performed the transplant in July 1999, but several severe postoperative complications followed, including the formation of a clot in the artery of the transplanted kidney. The clot was subsequently removed, but the transplanted kidney ultimately failed and had to be removed.

The patient resumed dialysis but experienced continuing complications and declining health. Eventually, he elected to discontinue kidney dialysis and he entered a hospice program where he died on September 24, 2000.

The mother initiated a wrongful death action against both Dr. Cohn and the hospital, alleging, among other things, that Dr. Cohn failed to disclose his actual transplant success rate. At trial, a plaintiff's expert denigrated Dr. Cohn's surgical abilities, testifying that five out of seven of Dr. Cohn's transplants failed in the months before this incident. The defense unsuccessfully attempted to introduce evidence regarding the precise patient circumstances surrounding those specific transplants that failed. In essence, the plaintiff alleged that there was no informed consent for the transplant procedure, because Dr. Cohn did not disclose statistical information regarding his surgical success rate. Following closing arguments, the jury awarded \$1.5 million to the plaintiff.

The defendants appealed, maintaining that the doctrine of informed consent does not require statistical disclosure of a physician's success rate when performing a specific procedure. According to the defendants, while the doctrine of informed consent requires a physician to warn patients of the possible risks entailed by a procedure, there is no requirement to disclose the individual surgeon's statistical success rates for specific procedures. Therefore, Dr. Cohn's failure to disclose his actual kidney transplant success rate did not violate informed consent. According to the defendants, the mere raw numbers of the successes and failures without underlying information on individual patient circumstances would bear little correlation to potential transplants anyway.

The Court of Appeals of Michigan reviewed not only the facts in this case but also the legal principles of informed consent. In the Appellate Court's view, bare numerical success rates can indeed be misleading. The statistical success and failure rates alone are unable to answer the question whether Dr. Cohn's transplants failed because of substandard technique or because of serious underlying health complications that existed in high risk patients under his care. In essence, a statistical failure rate for a procedure, standing alone, is not evidence of negligence. The Appellate Court found that the trial court had unfairly permitted the plaintiff's attorney to present statistics of Dr. Cohn's transplant failures in order to show that he "had a propensity to botch transplants." This clever ploy by plaintiff's attorneys intentionally left out extenuating patient circumstances, and the use of mere statistical failure rates was found to have the potential to punish defendants for the misfortune of a lower success rate because of involvement with high risk patients. Accordingly, the court ruled that parading statistics of Dr. Cohn's prior transplant failures had unfairly tainted the jury's verdict, and a new trial was ordered.

This case presents an excellent example of the ongoing dilemma of providing patients with informed consent. The underlying legal principle itself is simple: the physician must provide the patient with enough information so that an informed decision can be made. Generally, this involves an exploration of the nature of the procedure or treatment, the likelihood of success, any reasonable alternatives that are available, and the known inherent risks of the proposed procedure that are material to making an informed decision. For instance, thyroidectomy carries a well

known risk of laryngeal nerve injury which can result in hoarseness or loss of the voice. Obviously, this risk should be disclosed to the patient when a thyroidectomy is contemplated. The modern trend allows the jury to decide whether enough information has been disclosed for a reasonable patient to make an informed choice.

As with any general legal obligation, the requirement can be carried too far in certain circumstances. Here, the Court of Appeals of Michigan concluded that requiring physicians to disclose their statistical success rate with specific surgical procedures should not reasonably be required by the doctrine of informed consent. In addition the court found that disclosure of surgical success rates could prove misleading because of extenuating patient circumstances in prior high-risk cases. Bare statistics, standing alone, are no measure of either surgical expertise or negligence, and the Court correctly refused to impose a requirement on the surgeon in this case to divulge his individual statistics of transplant successes and failures.

# STANDARD OF CARE AND THE CESAREAN DELIVERY



Many factors have played a role in the evolution of modern obstetrical practice, including changes in patient characteristics, result expectations, cost control, and unease about

legal liability. Physicians and patients debate about the best care for specific obstetrical situations, including when to perform Cesarean delivery, and obstetricians are obligated to use their best clinical judgment to optimize the outcome for mother and baby. Medical research continues to identify situations when Cesarean delivery can be expected to improve outcome, but work also continues to identify circumstances where the Cesarean rate can be safely reduced. Such safe reductions will not only avoid the increased complication rates that accompany surgery, but also hold the promise of decreased costs without quality sacrifice.

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There is no unanimity of opinion on how to approach and treat certain obstetrical conditions. For example, some obstetricians who were trained otherwise were reluctant to accept the initial evidence of safety for vaginal birth after Cesarean birth (VBAC). Other obstetricians tended towards VBAC. Those who were trained in the arts of forceps used them to avoid some surgical deliveries and decrease the number of "repeat sections." Still others were not well trained in mid-pelvic forceps use and tended to avoid them. Despite well-founded differences of opinion on patient management within the obstetrics community, when a lawsuit is brought and negligence is alleged, the court must step in and identify a single applicable standard of care (SOC) against which to compare specific medical acts and omissions.

## History

In the 1960s and 1970s, the SOC pendulum swung away from vaginal towards Cesarean delivery based on academic publications that attempted to define “fetal distress” and which offered hope of avoiding cerebral palsy through timely intervention by delivery. Often delivery could be rapidly accomplished through Cesarean and its use increased. Based on the then-current belief that continuous electronic fetal monitoring (EFM) alone could detect early “fetal distress,” in the United States there was almost universal use of this technical development for all laboring patients. As an unintended result, the Cesarean rate increased. Only later was it learned that EFM lacked sufficient sensitivity and specificity to meet its promise.

Increased numbers of Cesareans were also performed based on a perceived need for strict adherence to the “Friedman Curve” of labor progress only to have this trend subside as understanding of epidural anesthesia and fetal physiology improved. Years later, supported in part by new publications that showed the fallacy of relying solely on EFM to avoid cerebral palsy, the pendulum began to swing back towards vaginal delivery.<sup>1</sup>

Because of these earlier expanded indications for Cesarean delivery and under the dictum “once a Cesarean, always a Cesarean,” many obstetricians began practice with little training in VBAC. In addition, data seemed to indicate that Cesarean deliveries increased safety for most breech babies and improved outcome for very low birth weight babies. At the same time there was evidence of higher rates of adverse outcomes with mid-forceps deliveries. A “skills gap” developed that became apparent only when indications for Cesarean delivery again

became more conservative: a great number of obstetricians had little experience or trust in the safety of VBAC or were untrained in mid-forceps use. Despite these learning deficits, today’s practicing obstetrician is expected to be comfortable with VBAC, vacuum assisted delivery, forceps, and Cesarean delivery.

While obstetricians conscientiously seek new information and techniques to improve their quality of care, unfortunately some promising innovations do not prove to be as beneficial as originally believed. One of the more glaring examples was the early reliance on readings from an EFM and the consequential harm from increased surgical rates. As disconcerting as this was in terms of patient welfare, the “science” of EFM use was admissible in court as a SOC. As a result, the obstetrician was at legal risk if a baby was born with cerebral palsy and a Cesarean was *not* performed. This legal threat provided even more pressure to increase the number of Cesarean deliveries. Today, we know that the accuracy and interpretations of EFM tracings were overstated, that earlier criteria for diagnosing “fetal distress” were inaccurate, and that cerebral palsy most often has causes unrelated to labor or delivery. Unfortunately, until this newer data was published, many physicians who were (wrongly) found by a court of law to have been negligent suffered personally and professionally.

**“Obviously, the obstetrician does not control many . . . factors that result in a higher Cesarean rate.”**

The increased surgical delivery rates, seen in several other economically advanced countries in addition to the United States, did not go unopposed. In 1985, the World Health Organization (WHO) published a worldwide target rate of 15% for Cesarean deliveries.<sup>2</sup> Later, in 2000, the American College of Obstetricians and Gynecologists (ACOG) published “benchmarks” for Cesarean delivery rates.<sup>3</sup> The ACOG accurately recognized that maternal, fetal, nursing, and non-obstetrical factors all influence the Cesarean rate and used statistical analysis to substantiate their findings and recommendations. Today--21 years after the WHO report--there are more elderly (in obstetrical terms) patients, multi-fetal gestations (often due to assisted reproduction techniques used), HIV positive patients, patients with active herpes, babies with very low birth weights, and patients with disturbing findings on antenatal surveillance who present for delivery.<sup>4</sup> Obviously, the obstetrician does not control many of these factors that result in a higher Cesarean rate. As such, the use of case-type specific information to establish a care standard for courtroom use is more fundamentally just than citing arbitrary numbers from an outdated publication.

“. . . the legal environment for obstetrical practice has changed and an obstetrician’s analysis of whether or not to recommend operative delivery may include the threat of litigation.”

In addition, the legal environment for obstetrical practice has changed and an obstetrician’s analysis of whether or not to recommend operative delivery may include the

threat of litigation.<sup>5</sup> As explained below, one of the analytic points for recommending a Cesarean delivery centers on what is reasonable or customary under the circumstances. Not only are medical factors part of today’s clinical circumstances, but so too are legal threats. Both, individually and together, place upward pressure on the Cesarean rate.<sup>6,7,8,9</sup>

Because Cesarean is usually a successful delivery method, despite inherent risks it most often appears to have patient benefit. A great deal of persuasion may be needed to reduce its use. Even so, alarmed at the increasing surgical delivery rate, and with a better understanding of perinatal anatomy and physiology, researchers and clinicians now conclude that the Cesarean rate can be safely reduced.<sup>10</sup> Even those physicians most dedicated to reducing the Cesarean rate, however, understand that universally accepted guidelines specifically applicable to every individual clinical circumstance and patient do not exist. As a result, there remains a subjective component of when to recommend Cesarean delivery.<sup>11</sup>

### Case Scenario

A gravida 3 para 2 patient returned to Dr. Hill for prenatal care. Her first delivery, 4 years ago, was normal spontaneous vaginal delivery at term. The second was also at term, but by low transverse Cesarean due to transverse lie. Throughout this third pregnancy, the patient, her husband, and Dr. Hill discussed whether to await spontaneous labor for VBAC, induce labor, or do a scheduled Cesarean delivery before labor.

Dr. Hill advised that the hospital did not have an in-house 24-hour per day anesthesiologist or operating room crew, and, given those circumstances, in her opinion repeat Cesarean

was safest. She also advised that VBAC was usually successful and had a low probability of uterine rupture. If rupture occurred, however, the results could be catastrophic especially if surgery was delayed. Dr. Hill promised to be with the patient throughout labor and delivery, if that was the choice, and would abide by the patient's decision.

The patient, with the concurrence of her husband, elected Cesarean delivery before labor. The scheduled Cesarean was completed without problems but 12 hours later the patient was found in bed without vital signs. Resuscitation failed and the post mortem examination showed that a pulmonary embolism (PE) was the cause of death.

A medical malpractice suit was brought against Dr. Hill because she performed a Cesarean delivery rather than VBAC, and PE is known to have increased incidence after Cesarean. The plaintiff, referring to published guidelines showing that induction of labor was medically acceptable after a single, low transverse Cesarean, claimed that it could have been done when the hospital was fully staffed. Pointing to Dr. Hill's Cesarean rate of 27% as compared to the WHO suggested rate of 15%, the plaintiff further alleged that Dr. Hill was motivated by financial gain to advise this Cesarean, and that punitive damages were warranted. Dr. Hill claimed that published guidelines setting out Cesarean rates are not standards of care, that she was constrained by hospital staffing, and that patient autonomy and informed choice should be respected. Unfortunately for Dr. Hill, the medical record did not reflect the full details of the information given to the patient prior to obtaining consent for surgery.

Dr. Hill's expert witness opined that the published WHO rate was inapplicable in 2005,

inapplicable to an individual case, and that medical ethics required respect for autonomy. While conceding that autonomy should be respected when the patient is fully informed, the plaintiff's expert cited published articles and alleged that Dr. Hill practiced below acceptable standards. The jury was instructed on the state's statutory definition of standard of care ("usual and customary"). Over defendant's objection, an additional jury instruction was given to consider a SOC as being established if it appeared in a peer-reviewed publication. The jury was unable to reach a verdict.

### **Discussion**

Many issues are raised by this case. Does the term "standard of care" mean the same thing to obstetricians and to courts? How does a SOC become recognized and disseminated among professionals? When do new techniques or treatments become a SOC? How do juries learn about medical standards of care without being exposed to "junk science"? If a physician practices within one SOC, is she nevertheless liable for damages because another SOC contradicts her action? In an individual case, does evidence that an obstetrician's general Cesarean rate exceeds that recommended by either WHO, a U.S. government agency, or a professional organization infer that she practiced below accepted standards in the case at bar? What should the jury consider in reaching its finding of fact?

Physicians and patients are justifiably dissatisfied with treatments for which scientific documentation of usefulness or safety is lacking, and this is no less true with Cesarean delivery. Where a new, peer-reviewed scientific publication ("evidence based medicine" or EBM) recommending a new care method clashes with a customary one that appears safe and useful, the physician faces a difficult

clinical choice over whether to adopt it. Even such published studies that initially appear to be correct may not be so in the long run. How many confirmatory studies justify acceptance? Unfortunately, attorneys and juries, often guided by “medical experts,” tend to place more reliance on the mere fact of publication than on the substance and substantiation required by physicians.

**“SOC is usually not a single, necessary medical act provided to alleviate a specific problem, but rather it is a continuum of choices and care that fall within a range of acceptable responses . . . to a given problem. . .”**

One problem posed by the dilemma is illustrated by Dr. Hill’s case. On one day she may be accused of performing too many Cesarean deliveries and on the next be accused of causing harm by electing a vaginal birth instead of a Cesarean (avoided because she tried to practice according to published guidelines). Had the patient in the scenario attempted VBAC and suffered uterine rupture, would Dr. Hill be absolved of responsibility for all resulting harm?

SOC is usually not a single, necessary medical act provided to alleviate a specific problem, but rather it is a continuum of choices and care that fall within a range of acceptable responses--not all of which have been academically studied--to a given problem. Where custom and EBM agree, or at least are not mutually exclusive, the jury’s task in determining whether an obstetrician’s actual handling of a specific case fell below the SOC is made easier. Where they

differ or conflict, there is less certainty that the jury will decide in favor of the health care provider.

### **Jury Instructions**

In the legal system, interpretation of law and enforcement of procedure are duties of the judge, while the determination of facts (fact finding) is that of the jury (unless it is a “bench trial,” in which the judge is the fact finder). Depending on the particular jurisdiction, the fact finder determining whether the specific health care fell below the SOC may be required to rely on medical custom, on EBM, or both.

A jurisdiction’s medical negligence statute sets forth the method by which a medical standard of care is established for legal purposes. The judge’s instructions to the jury must reflect the law as defined by statute. Florida’s statutory definition of medical negligence<sup>12</sup> is set forth as follows:

“Florida Statute Chapter 766.102  
Medical negligence; standards of  
recovery.

- (1) the claimant shall have the burden of proving...a breach of the prevailing professional standard of care... The prevailing professional standard of care...shall be that level of care, skill, and treatment which, in light of all relevant surrounding circumstances, is recognized as acceptable and appropriate by reasonably prudent similar health care providers.”

“A jurisdiction’s medical negligence statute sets forth the method by which a medical standard of care is established for legal purposes.”

A statute containing this or similar language allows the fact finder to be flexible in determining the SOC and contemplates that educational currency is customary among reasonably prudent similar health care providers. It also allows for the admission of evidence that a care method set out in a published guideline may or may not be applicable to the plaintiff’s specific case. Relevant medical publications may be presented in court, but need not be given great weight by the fact finder. While this “customary practice” standard allows for treatment variation according to circumstances of the individual case, a physician providing new treatment before it is widely adopted by her peers may be doing so at her legal peril. Discouraging improved treatment is not the intent of the “prevailing” type language, but it may well be a consequence thereof.

### Case Law

Jurisdictions are split on whether and how to admit new or novel scientific information into evidence. The import of this is that in some jurisdictions recently published medical findings may be used in court, while in other jurisdictions that same information may be excluded. Where the legal holding set forth in *Daubert v. Merrell Dow Pharmaceuticals, Inc.*<sup>13</sup> governs, the judge (who is usually neither a physician nor scientist) makes an initial determination, outside the presence of the jury, as to whether or not a study is scientifically valid, peer-reviewed, published,

and can properly be applied to the facts at hand. Finding in the affirmative, the judge will allow the admission into evidence of this new or novel scientific information or medical technique, whether or not it is widely accepted. *Daubert* is often criticized because there is less apparent evidentiary weight given to custom, experience, individual skill, or unique clinical aspects of the case. Further, not all relevant medical variables may have been recognized when the proffered study was completed. Subsequent studies, large series, and documented, published and analyzed clinical results eventually cure many of these problems, but in the interim the original data and conclusions can be presented to the jury if the judge decides to allow it. In malpractice cases, use of the *Daubert* approach alone seems too restrictive and could allow the fact finder to hear inaccurate or perhaps outdated information. One can only hope that a modern judge would exclude a study such as the 1985 WHO recommendation, but there is no legal mandate to do so merely on the basis of its publication date.

Another approach to admitting scientific information into evidence is established in *Frye v. United States*.<sup>14</sup> In *Frye* jurisdictions, the proposed evidence must be “generally accepted” in the relevant scientific community and the judge lacks the “gatekeeper” powers that *Daubert* assigns. *Frye* allows more flexibility in admitting evidence of an acceptable SOC because the relevant community (practicing obstetricians, in Dr. Hill’s case) often considers variables that have not yet been, or cannot be, statistically evaluated. It also allows the jury to look at the plaintiff and physician-defendant as individuals in a specific clinical circumstance and to more fully consider and weigh all of the relevant factors presented by both parties.

**“When a Cesarean is recommended or performed, the physician should be able to medically and ethically support it . . .”**

### **Good Practice**

In the real world, there is no “ideal” Cesarean rate. While efforts to reduce unnecessary Cesarean deliveries are important, an arbitrary statistical goal set for its own sake is not the ultimate desired result.<sup>15</sup> One must use best judgment based on clinical circumstances and medical facts to ensure that the influence of published guidelines does not, as an independent factor, add to morbidity and mortality by influencing obstetricians to avoid otherwise-indicated Cesarean deliveries.<sup>16</sup> When a Cesarean is recommended or performed, the physician should be able to medically and ethically support it, including honoring patient autonomy. Decisions based on honoring autonomy do not appear in general medical statistics.

It is good medical practice to make contemporaneous clinical chart notes setting forth the reasons for any advice given; all discussions about alternatives, benefits, and risks; and what the patient should expect if professional advice is not taken. Legally, this constitutes part of “informed consent.” The notes should also state who participated in or witnessed the conversations and should not only be dated, but the time indicated as well. These notes need not be academic tomes, but should set out the justification for care in sufficient detail to allow a reviewer to conclude that the SOC was followed and to remind the health care provider of the details if he or she is

called upon at a future date to defend his or her actions.

This is not to say that a physician can do as he or she pleases simply by documenting that his or her cases have been successful and free of complications. Cesarean deliveries performed solely for physician convenience or for economic gain, for example, are not in the patient’s best interest and have no place in medical practice. A related issue presently under debate is the inverse which also places upward pressure on the Cesarean delivery rate: how to respond to patient requests for Cesarean delivery where there is no recognized medical or psychological need (termed “Cesarean on demand”). This movement is relatively new and arguments for and against it are presently being articulated. Some argue that it should be done to preserve perineal function, while others argue that Cesarean is not an important factor in the changes noted after delivery. Some argue that if cosmetic surgery is available by choice, Cesarean delivery should be as well.

### **Which SOC?**

For most obstetricians, standard of care means practice that considers scientific data, experience, custom, prudence, individual patient need, patient autonomy, physician skills, and available medical services. It contemplates application of sound clinical judgment and leads to a final treatment selection that includes the art as well as the science of medicine. Sometimes, it is the “art” that is later attacked in court if there is bad outcome. Each patient deserves full, individual consideration.

In a court proceeding, a plaintiff’s case often relies on statistics in the abstract or on an alleged violation of a general SOC, neither of

which may have specific application to the case at hand. Fortunately, finders of fact are usually reasonable and make their determinations of liability based on *all* of the relevant evidence, including that of the applicable “art,” weighing and applying each factor.

Where an informed obstetrician holds the good faith belief that he or she can avoid stillbirth or damage through surgery and the mother and baby leave the hospital in good health, was the standard of care violated merely because a Cesarean was performed instead of first trying vaginal delivery? In the alternative, where the physician under like circumstances in good faith follows peer-reviewed published guidelines that advise the avoidance of Cesarean and this results in damage or death, was the standard of care violated? While courtroom instructions state that an adverse result does not equate to negligence, in reality does outcome, *per se*, matter? An obstetrician’s belief that fact finders are outcome motivated may contribute to what he or she views as reasonable care under the circumstances.

Two major themes have been interwoven throughout this article. The first is that where there is no statistically validated solution to every obstetrical circumstance, there can be no universal rate for the total of all Cesareans. Where there are conditions with commonly accepted definitions, rate goals based on large population studies may be a valid basis for comparative purposes. However, this in no way establishes what should be done in a single specific case. The second theme is that neither peer review committees nor courts of law can determine a universally valid medical standard of care based solely on custom or solely on statistics and publication. In attempting to adjudicate a malpractice proceeding, a good

faith, detailed analysis of all relevant factors in the specific case must be considered. This should include the obstetrician’s analytical approach to the problem and rationale for treatment. Adverse results do not always mean that negligence occurred.

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16. Id. The ACOG is careful to state that “the information . . . should not be viewed as a body of rigid rules. The guidelines are general and intended to be adapted to many different situations, taking into account the needs and resources particular to the locality, the institution, or the type of practice. Variations and innovations that improve the quality of patient care are to be encouraged rather than restricted.”

# Med/Mal 101: The Expert Medical Witness

By Robert Hurwitz, M.D., FACNP\*



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Health care providers are often asked to serve as expert or fact witnesses in legal proceedings. Courtrooms and depositions can be intimidating and have their own rules that require considerable preparation for anyone choosing or being required to testify. This article reviews the basics for those who wish to or are compelled to enter this unfamiliar territory.<sup>1</sup>

## **Guidelines**

Each state has its own rules, but well qualified physicians or other health care providers can testify in any of the 50 states if they are qualified by knowledge, skill, experience, and education. An expert must have specialized knowledge in his or her field to assist the “finder of fact” who may be either a judge or a jury.

Simple rules of thumb are: 1) that the expert must work full time in his specific field of health care and 2) that an expert will not be permitted to testify about issues outside his own scope of practice. An obstetrician, for example, would not be allowed to discuss any opinion about a “missed” hip fracture. A retired nurse would not be permitted to address recent Joint Commission guidelines on avoiding medication errors.

If one enters this legal arena, it is appropriate to charge for time to review a case, time to give deposition testimony, and time to testify at trial. Such charges are remarkably similar throughout the country. It is best over one’s career to take cases for both plaintiffs and defendants, as this demonstrates to the court a balanced approach and lends credibility to testimony. We have all heard of “hired guns” who can be manipulated by counsel.

### **What Is Asked of An Expert?**

Medical malpractice cases are an unfortunate fact of life for the practicing physician. Patients may be angry with their medical care, no matter how optimal. They sometimes feel wronged, claiming delay of diagnosis, improper management, or a “bad” result. Some patients simply want their “day in court.” A designated expert may discuss diagnosis, prognosis, causation, impairment, and in some cases, disability (but this latter is most frequently done by certified Independent Medical Examiners). An expert must review each case objectively.

A medical expert’s curriculum vitae will always be requested by all parties. It should be up to date and accurate.

### **Courtroom Etiquette**

Whether in deposition or at trial, testimony by a medical expert must be truthful and support-

ed by written source material such as the medical records, standard texts, and journals in that field of expertise.

An expert’s oath to testify truthfully is first taken by the court reporter. While attorneys may joke in court, an expert is expected to behave with seriousness of purpose and to ignore distractions. The judge is in charge of his courtroom and all of his instructions are to be followed to the letter.

Experienced experts follow simple rules given by the legendary attorney, Melvin Belli, Sr.<sup>2</sup>

- Approach the stand in a normal manner, glancing neither to left or right.
- Sit upright with attention directed to the attorney asking the questions.
- Answer all questions in lay terms and as concisely as possible.
- Ask to use simple models to illustrate medical anatomy and pathology to the court. (With experience, however, PowerPoint presentations can replace the plastic models and clumsy illustrations of past years.)
- When medical terms must be used, they should be explained to the jury as if to any patient. The expert is viewed as a teacher, imparting medical knowledge and the factual basis.
- Allow each attorney time to finish his or her questions before answering. Always pause briefly to permit any objections to be lodged. This also gives the expert time to formulate a brief and concise answer.

The term “court fright” is similar to “stage fright.” Placing oneself and the court in an imaginary clinical setting can restore confidence. Expert witnesses should be realistic and objective, but there is nothing wrong, however, with allowing the image of a caring and compassionate health care provider to shine through. Any eye contact with judge or jury should be brief, with attention largely riveted on the attorney asking the questions.

### **Daubert Case Law**

In 1993, the Supreme Court ruled on *Daubert v. Merrell Dow Pharmaceuticals, Inc.*<sup>3</sup> Every expert should be familiar with this ruling. It was held that any trial court shall serve as a “gatekeeper” of evidence to be submitted. The Supreme Court further held that “each court shall ensure that any and all scientific testimony or evidence is not only relevant, but reliable.” There must be a “grounding in the methods and procedures.” The knowledge “must be derived by the scientific method” to establish reliability, and the knowledge must be “relevant” to the facts of the case.

*Daubert* contains the guidelines for testimony for a medical expert witness (must be in your area of expertise) and written support (must be from standard texts and medical opinions in your field). The penalty for straying from these guidelines is the embarrassment of being disqualified by the court from testifying. The first question by opposing counsel is almost always, “Have you ever had a court disqualify you?”

### **Legal Terminology**

The legal profession uses language that must be understood by a medical expert if he or she is to be taken seriously.<sup>4</sup> A brief list of such terminology includes the following:

**Aggravation:** An ongoing effect which results in physical worsening or accelerating of the underlying pathology.

**Apportionment:** A clinical estimate of what resulted in the condition and the relative weights of responsibility that should be assigned to certain events or persons.

**Clinical Guidelines:** Professionally derived recommendations for practices and patterns of prevention, medical diagnosis and treatment.

**Defendant:** A doctor, nurse, hospital employee, or hospital accused of medical malpractice.

**Disability:** A physical or mental impairment that substantially limits one or more major life activities of an individual. Such disabilities are most frequently quantified by board certified Independent Medical Examiners or neuropsychologists.

**Exacerbation:** A temporary increase in symptoms.

**Fact Witness:** A health care provider who participated in either inpatient or outpatient care of a patient and who can be subpoenaed to testify about care rendered and all chart notes and opinions. This individual is not compensated for such testimony.

**Expert Witness:** An experienced and objective health care provider who reviews all pertinent medical records. Such a witness enables the judge and jury to reach conclusions on medical issues. Compensation of such a witness is perfectly proper.

**Impairment:** The loss of use or a disorder of any body part, system, or function. This must be documented by a proper medical assessment.

**Malingering:** The purposeful misrepresentation of a disability. Such a term should not appear in a patient's medical records unless documented by qualified psychiatrists and neurologists called in as consultants.

**Multifactorial Causation:** Several causes of a problem. An example would be post-operative infections in a patient with underlying diabetes or an immune compromised state.

**Possibility:** Less than a 50% chance.

**Probability:** More than a 50% chance. The phrase "more likely than not" is key to medical-legal proceedings.

**Proximate Cause:** The factor which immediately or closely preceded the subsequent symptoms. A jury certainly understands that if an otherwise healthy defendant is involved in a severe automobile accident and then spends three weeks in a coma, the automobile accident is a proximate cause of the coma.

**Recurrence:** The medical condition in question returns without an obvious or documented trigger incident.

Knowing this mini-vocabulary will be enormously helpful to expert medical witnesses. These phrases will be used in every question you are asked, both in deposition and at trial.

## Legal Situations

Actual trial lawyers often act like those viewed on television shows. They have every intent of using tactics that over and over again have proven successful when examining expert witnesses.<sup>5</sup> If the stress from intense questioning detracts from your personal clinical work, you should reconsider making yourself available for expert testimony.

### 1. Difficult questions that are always asked

It is routine for attorneys to pepper an expert with questions, either at deposition or at trial. If one is prepared and responds calmly, none of these questions should be a problem.

- How many cases have you testified in, doctor?
- What percentage of your time do you testify for plaintiffs? For defendants?
- Did you talk to the treating physicians before forming your opinion?
- Have you ever published an article that relates to the situation at hand?
- Who are national experts in this field?
- Have you ever heard of Dr. John Doe at XYZ University?
- What are authoritative textbooks that cover the issues in this matter?
- What were you hired to do?
- Summarize the medical history of this patient, doctor!
- What are your opinions, and on what do you base those opinions?

- How do you account that twelve other physicians hold opinions differing from yours?
- How many hours have you spent in reviewing this case?
- Is another expert who holds a different opinion automatically wrong?

## 2. Witness protocol

There are simple rules to follow to avoid becoming flustered or tricked into giving incorrect testimony.

- Permit counsel to complete his or her question without interrupting.
- Ask that complex questions be repeated or broken down into simpler questions that both you and the court can address.
- If any attorney lodges an objection, calmly wait for the objection to be stated and for the judge to rule on the objection.
- Do not allow counsel to upset you. Answer questions in a dignified, calm manner.
- If counsel repeatedly asks the same question over and over, point out that you have already answered that question.

## 3. An antagonistic lawyer who uses bullying tactics

- Keep cool on the “hot” seat. Jurors have sympathy and respect for a witness who does not lose his or her temper.

- An attorney may use trick or compound questions. Ask that these be broken down into simpler questions. Both you and the jury will be able to follow simpler questions more easily.
- An attorney might turn his back as if finished but then strike back with a final question. Do not relax or lower your guard until the attorney states, “That is all, doctor, you are excused.”

## 4. When may you address the judge?

- If the judge specifically asks you, the witness, a question.
- If the lawyer examining you seeks an answer that may be privileged. You are entitled to ask the judge when you should or should not answer.
- If, on cross-examination, you are repeatedly demanded to answer “yes” or “no,” you may turn to the judge and express your opinion that an answer must be explained more fully than only “yes” or “no.” Wait for instructions.

## 5. Courtroom attire

- Wear conservative attire such as a dark suit for men and a similarly conservative outfit for women.
- No campaign buttons or political neckties. A juror might subconsciously object to any bias of the witness. They want only to hear the facts of the case.

### **Position Statements of Organized Medical Societies**

Medical societies have long been involved in issues regarding expert witness testimony.<sup>6</sup> In 1992, the American Medical Association (AMA) and numerous medical specialty societies participated in the AMA/Specialty Liability Project. This joint panel filed an *amicus curiae* brief in *Daubert*.

Current policies of these learned societies may be summarized as follows:

- As a citizen and as a professional with special training and experience, a physician has an ethical obligation to assist with the administration of justice.
- The medical witness must not become an advocate or a partisan in the legal proceeding.
- The medical witness should be adequately prepared and should testify honestly and truthfully.
- The attorney for the party who calls the physician as a witness should be informed of all favorable and unfavorable information developed by the physician's evaluation of the case.
- It is unethical for a physician to accept compensation that is contingent upon the outcome of the litigation.

There are consequences to expert witnesses who knowingly violate these guidelines. Medical societies track expert testimony. Medical experts should be aware that transcripts of depositions and courtroom testimony are public records subject to review by colleagues and professional organizations.

False or misleading testimony given to the court may lead to peer review and discipline by the expert's own medical society.

### **Personal Experience**

I have observed that trial testimony is helpful in my own clinical practice of medicine, but courtroom experiences can be a world apart from everyday health care. Three examples follow.

#### **Example 1.**

##### **“If It Doesn't Fit, You Must Acquit”**

The late trial attorney Johnnie Cochran coined this phrase. Often times, even in a tedious trial, a dramatic event or demonstration will carry the day. Expert A was informed by telephone that in opening arguments opposing counsel used a plastic, water-filled Coca-Cola bottle to demonstrate how free air must rise to the surface of a water-filled bottle if there has truly been an episode of spontaneous perforation of bowel.

With little difficulty Expert A duplicated this same demonstration, but also poured bands of “super glue” into the bottle. In court, when Expert A showed the bottle filled with water and air and bands of glue, it clearly demonstrated to the jury that pockets of free air trapped by adhesions (the glue) can also be a sign of bowel perforation. The court allowed this last minute demonstration because counsel had used something similar in his or her opening arguments. The jury found for the defendant physician.

#### **Example 2.**

##### **When an Expert Disappoints the Court**

In a second case, Expert B appeared in defense of a physician. His or her testimony was factual and to the point. In this particular court, the jurors were allowed to submit additional

written questions that they felt counsel had not asked or clarified. The judge read these questions to Expert B, who was permitted to directly address the jury on each and every matter.

The plaintiff's expert, however, had felt this case to be so straightforward that she chose to prerecord video testimony that would be played before the jury. The jurors may have been impressed by his or her qualifications, but felt frustrated that other experts had made themselves available in person for questioning. The outcome of the case was for the defendant physician.

### **Example 3. Juries Do Not Like To See an Expert Harassed**

Expert C had made clear to all counsel and the

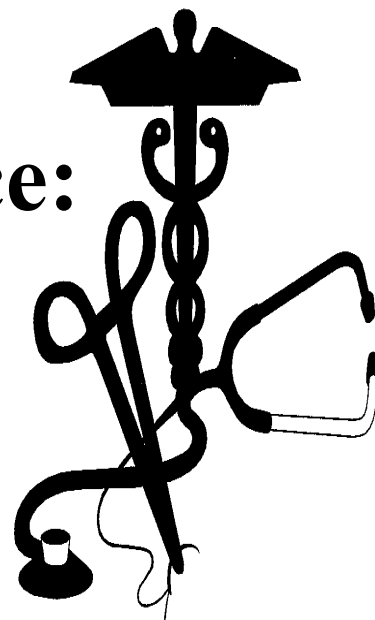
Judge (at 9 a.m.) that his testimony was limited to one day only. Regardless of any fee to appear, full-time physicians have commitments to their patients. Opposing counsel purposely took other experts out of order to create a limitation in his or her time to question Expert C. He then said, "Let's continue this matter tomorrow" in an attempt to rattle the witness. Counsel was promptly scolded by the judge and all further questions were cut off at the usual closing time of the court, 4:30 p.m.

In summary, expert testimony can be an intellectually rewarding part of one's practice. It is an optional part of the medical profession, and comes with responsibility and adherence to the ethical guidelines illustrated above.

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# Avoiding Medical Malpractice: Lessons Learned From The Orthopaedic Literature



By Matthew E. Oetgen, M.D.\*

**In recent years there has been a renewed interest in medical liability and malpractice in the popular press.** The cause of this increased coverage comes from a variety of sources, including public interest in medical errors since the Institute of Medicine report “To Err Is Human,”<sup>1</sup> recent high-profile malpractice crises seen in states such as Nevada, and the current political administration’s attempts at tort reform. Increased interest in the current malpractice system has unveiled disturbing trends in medical malpractice.

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The indemnity payment and frequency of claims has steadily risen over the past several years. Since 1997 the mean plaintiff’s verdict in a medical malpractice claim has increased from \$1.97 million to \$3.48 million. The percentage of indemnity payments in excess of \$1 million had increased from 34% to 52% in the same time period. The frequency of malpractice claims has increased as well, with high risk specialties now reporting a 30-50% increase in frequency of claims.<sup>2</sup> As a likely consequence of these factors, the cost of malpractice

insurance has risen dramatically, thus changing a practitioner's ability and willingness to practice in some geographic regions or some medical specialties.

The field of orthopaedic surgery is experiencing this same trend. It is reported that the frequency with which orthopaedic surgeons are involved in a malpractice claim is roughly 30%. In other words, for a given group of policyholders, an average 30% will be involved in a claim each year.<sup>3</sup> The frequency of malpractice claims appears to be increasing.<sup>4,5</sup> Of these claims, approximately 30 to 35% eventually result in indemnity payment, either through a trial verdict or a settlement.<sup>6,7,8</sup>

**“Since 1997 the mean plaintiff's verdict in a medical malpractice claim has increased from \$1.97 million to \$3.48 million.”**

Although the legal profession cites the current punitive state of medical malpractice as useful to deter physicians from negligence, studies have found a disconnect between injury and litigation.<sup>9</sup> In the Harvard Medical Practice Study it was found that the majority of malpractice claims have no basis in medical negligence, and the strongest predictor of payment in a malpractice case was the severity of the plaintiff's condition, not negligence or medical causation.<sup>10</sup>

The rising cost and frequency of malpractice claims coupled with the ineffectiveness of the current malpractice process signals problems within this system. Sweeping reforms, although justified, have been slow to materialize due to political and social factors. A review of the orthopaedic literature reveals numerous studies

that have investigated personal characteristics and practice habits that are associated with a higher rate of malpractice claims. A detailed review and explanation of these factors may assist individual orthopaedic surgeons (and other physicians as well) in avoiding malpractice litigation while systemic malpractice issues continue to be discussed.

### **Malpractice Overview**

In general, the basis of a malpractice claim is medical negligence. Legally, to make a successful claim of negligence, the plaintiff must show that the physician defendant had a duty to the patient, that the duty was breached, and that the breach resulted in harm to the patient.<sup>11</sup> This definition of negligence opens areas of argument as to exactly what constitutes negligent care. Duty of care means the physician has a duty to provide care that conforms to the standard of care. The definition of standard of care is somewhat arbitrary. The standard of care physicians have been held to has traditionally been defined by the geographic area in which they practice, but this has changed somewhat to be understood as the standard of care within the particular medical specialty of care. The testimony of “expert witnesses” is customarily used to define the standard of care in malpractice cases.

### **Avoiding Malpractice Suits**

There have been numerous studies investigating malpractice claims against orthopaedic surgeons. In the majority of claims the reason for negligence is an error associated with an operation performed. While the very nature of operative intervention introduces some degree of uncertainty to the eventual outcome, a subsequent malpractice claim being filed is not always associated with a negligent operation or poor outcome. This was detailed in the Harvard Medical Practice Study<sup>12</sup> that

found a minority of malpractice claims associated with negligent care as well as a minority of cases of negligent care generating malpractice claims, indicating the subjective nature of malpractice claims.

**“. . . there are several recurring factors associated with malpractice claims that have been identified in multiple studies. These are physician-patient communication, physician characteristics, and informed consent.”**

Importantly, there are several recurring factors associated with malpractice claims that have been identified in multiple studies. These are physician-patient communication, physician characteristics, and informed consent.<sup>13,14,15,16,17,18</sup> One of the common themes associated with these factors is that they may be addressed by physicians themselves, thus possibly decreasing the risk that a malpractice claim is filed, even in cases of negligent care or poor outcomes.

### **1. Communication**

The basis for any relationship is communication, and this holds especially true for the physician-patient relationship. Due to the uneven balance of information pertaining to diagnosis, options for treatment, and potential outcomes, patients heavily rely on the physician for open communication. It is not unexpected, then, that many studies have found communication (more importantly how the patient perceives this communication) as an important factor in malpractice claims.

The importance of communication was shown in a survey of malpractice attorneys performed by Kilmo and colleagues.<sup>19</sup> The goal of this study was to ascertain the perceptions of attorneys regarding orthopaedic medical malpractice claims. The attorneys listed poor physician-patient relationships as a factor in 31% of orthopaedic malpractice lawsuits. Further analysis revealed that the main contributing factors to a poor physician-patient relationship included: 1) the physician appeared to be rushed or uninterested, 2) the physician's failure to return messages, 3) poor communication to the patient of realistic treatment expectations, and 4) rude or condescending physician attitudes.<sup>20</sup>

In another study, Hirsh and White analyzed over 1500 closed malpractice claims and found negligent post-operative care to be the most frequent cause of malpractice claims for orthopaedic surgeons. These complaints primarily related to care which was “brief, superficial, and inconsistent,” and they all fell within the parameters of poor physician-patient communication.<sup>21</sup>

The basis of good physician-patient communication was investigated by Adamson and colleagues.<sup>22</sup> They examined the physician-patient relationship in terms of three physician virtues: rapport, ability to explain, and physician access. The authors found an inverse relationship between physician virtues and number and costs of malpractice claims. In essence, physicians who were able to build better rapport with their patients, spent more time with their patients, and allowed easier access for their patients were involved in fewer malpractice claims. Additionally, of the claims in which they were involved, the indemnity

payment was less than for those physicians without good patient relationships.<sup>23</sup>

**“. . . these findings indicate that physicians who are more educationally accomplished and less professionally isolated are less susceptible to malpractice claims.”**

**2. Physician Characteristics**

Characteristics of the physician seem to be another important factor in medical malpractice claims. It is difficult to assess this area, but some possibilities involve improved communication, improved patient trust, or simply superior physician skill.

Adamson and colleagues<sup>24</sup> studied the relationship between personal, educational, and practice characteristics of surgeons and their malpractice claims. Although they studied a variety of surgical specialties, the high number

of orthopaedic surgeons evaluated allowed separate analysis of this group. All physicians were members of a California-based liability trust, and were surveyed regarding personal, education, and practice characteristics. They were then compared to a group of physicians who had been terminated from the trust due to their high number of claims. Physicians were analyzed according to the number of malpractice claims in which they were involved: no claims, low claims rate (<0.13 mean claims/year), high claims rate (0.54-0.61 mean claims/year), and terminated (0.9-1.4 mean claims/year). Several factors associated with being in the “no claims” to “low claims” group are shown in Table 1.<sup>25</sup>

Multiple regression analysis found two factors to be significant predictors of the number of malpractice claims per year: clinical faculty membership and membership in professional societies. The authors suggest these findings indicate that physicians who are more educationally accomplished and less

<b>Physician Characteristics Affecting Malpractice Claims Rates</b>			
<u>Factor</u>	<u>Low Claims Rate</u>	<u>High Claims Rate</u>	<u>P value</u>
Born in United States (%)	97	68	<0.001
International Medical School Graduate (%)	4	32	<0.001
Clinical Faculty Appointment (%)	71	0	<0.01
Membership in Professional Society (# of Societies)	1.9	1	<0.01

**Table 1**  
(Data from “Characteristics of surgeons with high and low malpractice claims rates.” See reference 14.)

professionally isolated are less susceptible to malpractice claims.<sup>26</sup>

In a subanalysis of the same study, Baldwin and colleagues evaluated the relationship between moral reasoning, as assessed by a validated written test of moral reasoning, and rate of malpractice claims.<sup>27</sup> While the number of individuals participating in this study was low, an interesting finding was seen. Higher levels of moral reasoning showed a protective effect against malpractice claims. The authors concluded that, due to the lower incidence of malpractice claims, those physicians with higher moral reasoning exhibited better clinical performance. While a conclusion of better clinical performance may appear to be unfounded due to the previously shown lack of correlation between malpractice claims and actual negligent care, there does appear to be a relationship between moral reasoning and incidence of malpractice claims filed.

### 3. Informed Consent

Patients have the right to decide what medical treatment they will accept. As part of this, surgeons must provide informed consent regarding any invasive procedure the patient undergoes. Informed consent for a surgical procedure means that the patient understands the benefits of the procedure, risks of the treatment, alternative options to the proposed treatment, and consequences of declining the treatment. When this information is provided to the patient, it is assumed he or she will make a reasonable judgment regarding their desire to proceed. If informed consent is obtained and a patient suffers a known complication not associated with negligent care, the physician may not be held liable.<sup>28</sup> Although the need for informed consent is obvious and intuitive before scheduled surgical procedures, Gould

and colleagues found improper informed consent was the second most common cause of malpractice claims involving orthopaedic care in the emergency department setting.<sup>29</sup>

In order to analyze the effects of informed consent on indemnity payments, Bhattacharyya and colleagues studied closed claims of orthopaedic surgeons from a single state over a 24-year period.<sup>30</sup> They found these claims had an indemnity payment in 36% of cases, slightly higher than the rate for all claims against orthopaedic surgeons. Issues of informed consent that led to a high incidence of indemnity payment were discrepancies in the surgical site on the informed consent and consent obtained in the hospital or pre-operative holding area for elective cases. Documentation of the informed consent in the dictated operative note or office note and consent obtained in the office prior to the procedure were both found to be associated with a lower risk of indemnity payment. The authors concluded that obtaining informed consent in an office setting prior to the procedure is likely associated with a better environment for communication of the issues required in the consent, thus leading to fewer indemnity payments. Additionally, they felt their data showed the importance of extra documentation of the informed consent in an operative or office note.<sup>31</sup>

**“Complete and proper documentation of all medical encounters cannot be emphasized enough when discussing malpractice claims.”**

### Other Issues

Two additional issues frequently discussed when analyzing malpractice claims cases are documentation and patient population.

Complete and proper documentation of all medical encounters cannot be emphasized enough when discussing malpractice claims. The old adage, “If it is not documented, it did not happen,” holds true time and time again in malpractice claims. Medical documentation provides concrete evidence of the actions the physician took when malpractice cases are analyzed. All documentation must be complete, dated and timed, and legible to be useful.<sup>32</sup>

A common misconception about malpractice claims is that indigent populations are more likely to file malpractice claims. This has been shown to be untrue in a number of different studies.<sup>33,34</sup> There are many physician-dependant factors that can and should be addressed to decrease the risk of a malpractice claim, rather than selecting specific patient populations to treat based on their assumed malpractice claims risk.

### Conclusion

The past few years have seen a rise in the frequency with which malpractice claims are filed and an increase in the indemnity payouts in these cases. Although this trend has been documented in orthopaedic surgery, it is definitely not confined to this field. This is, in fact, a problem seen throughout the entire medical profession. Overall, and for a variety of reasons, a malpractice claims frequency of roughly 10% has been reported and is likely increasing.<sup>35</sup>

In reviewing the orthopaedic literature, there appear to be numerous issues that individual

physicians may address in order to lower their risk of involvement in a malpractice claim. The overwhelming theme of these issues seems to be the importance of good communication between the physician and patient. The balance of knowledge in the physician–patient relationship lies overwhelmingly with the physician, and this increasing imbalance will only grow as medical knowledge and technologies expand. It appears the chasm between the physician and patient has the potential to lead to malpractice claims in response to patient unhappiness or adverse outcome, even when negligent care was not rendered. Physicians must recognize this issue and pay particular attention to good communication and a good working relationship with the patient.

Developing a true partnership with a patient, rather than applying the traditional paternalistic relationship that often exists in medicine, can often help the physician avoid a lawsuit. Nurturing an open, trustful, and mutually agreeable relationship seems to be the best protection against medical malpractice claims in these litigious times.

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# PHYSICIAN-PATIENT EMAIL

*By Jerome VanRuiswyk, M.D.\* and Zia Agha, M.D.\*\**



Technology infrastructure that can support physician-patient email communication has been available for several years. Headlines in the popular press tout email as another way to access doctors<sup>1</sup> or as a means for doctors to control their access to patients.<sup>2</sup> The Institute of Medicine in its landmark report “Crossing the Quality Chasm: A New Health System for the 21st Century”<sup>3</sup> endorses email as an important tool to increase the quality and efficiency of patient-centered health care. And published opinions in the medical literature suggest that physician-patient email could have a profound impact on physician-patient interactions<sup>4</sup> as well as the potential to increase the efficiency of chronic disease management.<sup>5</sup> So why is it that the use of physician-patient email has diffused so slowly into clinical practice? Some doctors believe that physician-patient email would make them too accessible to patients<sup>6</sup> and would create administrative difficulties. Many, too, worry about the legal and ethical ramifications involved.

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**“It appears that a significant number of patients would utilize physician-patient email communication if their doctors offered this service.”**

## **Patient Perceptions**

It appears that a significant number of patients would utilize physician-patient email communication if their doctors offered this service. In a survey of 950 patients attending appointments at six family practice clinics in central Texas, researchers found

that between 33% and 75% of outpatient clinic populations had email access. If email communication with their physician were available, 90% of patients indicated they would use the service to request prescription refills, 87% would use it for non-urgent consults, and 84% would use it to obtain test results.<sup>7</sup> In a different study, 1421 patients responding to a survey about electronic health records indicated that they preferred email communication for interactions such as requesting prescription refills or learning general medical information, but preferred in-person communication for obtaining treatment instructions. Interestingly, these patients indicated that telephone or written communication was never their preferred communication channel, while their physicians were more likely to prefer telephone communication instead of email communication.<sup>8</sup>

Despite patient satisfaction with email communication and apparent broad demand for this service, its use remains limited. In a national sample of adult Internet users, only 6% reported using email to contact their doctor or other health care professional.<sup>9</sup>

### **Physician Factors**

Doctors are reluctant to use email to communicate with patients, and even those physicians who offer the service are using it to communicate with only carefully selected patients due to uncertainties about how to incorporate email into the office workflow. Physicians who do use physician-patient email report that it enhances chronic disease management.<sup>10</sup> Most physicians report using email to communicate with <5% patients, citing concerns about additional workload, information security, lack of reimbursement for email care, and possible legal and liability issues. However, secure web messaging, which

requires users to log on to a password-protected website and which supports the use of message templates and message routing, can potentially overcome some of these concerns. In a study that used secure web messaging and incorporated insurance reimbursement capability, physicians preferred email communication with patients instead of telephone calls for non-urgent problems.<sup>11</sup>

### **Effect On Communication**

Physician-patient communication via email has some risks compared to in-person or phone communication. Since email communication is limited to text, it eliminates all nonverbal cues. This can completely change the quality of the information exchange. Since email is an asynchronous mode of communication, it is an inefficient method of conducting a dialogue and is not suited to time-sensitive communications. Because of this, using email may increase the risk of delay-related harms. In addition, it is difficult to check patient comprehension of physician emails. If patients do not read or understand their physician's emails, this could lead to serious medical errors and possible medical liability issues.

However, there are complementary benefits of physician-patient email. When email is used as a supplement to traditional in-person care, it can increase efficiency of routine responses. Since email can be content rich it can provide patients with detailed medical instructions and patient education material that is either attached or embedded as HTML links. However, since web links imply endorsement of services, information, or products, providers should avoid links to particular hospitals or health plans that might raise antitrust, kickback or self-referral concerns.<sup>12</sup> Proactive email reminders can help patients and providers manage chronic disease, improve preventive

health care, and improve adherence to a medical regimen. Such a model of email enhanced physician-patient communication could increase patient participation in self-care, improve shared decision-making, and strengthen the physician-patient relationship.

**“Physicians remain wary of the impact of physician-patient email on clinic workload and workflow.”**

#### **Effect On Workload and Medical Resources**

Physicians remain wary of the impact of physician-patient email on clinic workload and workflow. While physician-patient email could substitute for other non-reimbursed activities such as telephone calls, physicians worry that providing this additional means of obtaining care could lead to an overall increase in non-reimbursed work. Some published data validate these concerns.<sup>13</sup>

On the other hand, from a managed care perspective, physician-patient email, to the extent that it averts other more costly types of visits, may reduce the overall cost of care. Blue Shield of California sponsored an independent evaluation of a program that used a secure online communication system that included clinically structured, branching interviews, and provided reimbursement to physicians plus charged a small co-pay per patient use of email.<sup>14</sup> The demonstration project recruited 282 physicians with 3,688 patients who were matched to a control group of patients with similar demographics including internet access. Investigators found that patients who used email to communicate with their physicians were 50% less likely to miss work due to an illness, 45% less likely to visit the doctor, and

36% less likely to phone the doctor’s office. This led to a small net reduction in total health care costs.

#### **Legal Issues**

From a legal standpoint, email is best suited as an adjunct to in-person or telephone within the context of an existing physician-patient relationship. Patients must be informed of policies regarding message response times, and providers must have contingency procedures for staff absences. Both the inherent lack of nonverbal clues and the inability to perform a physical exam limit the data set available for making diagnoses via email. Therefore, its use should be targeted to health maintenance, preventive care, and follow-up of chronic illnesses.

**“Confidentiality issues associated with traditional email also apply to physician-patient email.”**

Confidentiality issues associated with traditional email also apply to physician-patient email. For example, employers who own their email systems also own any messages sent or received over them. In legal proceedings, employers or online providers may be forced to disclose the content of emails received or sent. Since there is a lack of relevant case law, uncertainty remains about how judges and juries in malpractice cases will view physician-patient email communications. Given physician-patient email’s evolving standards of care, inherent limitations, and related confidentiality issues, legal experts recommend documenting informed consent for email use from participating patients.

“. . . legal experts recommend documenting informed consent for email use from participating patients.”

### Regulatory Issues

Federal and state regulations both apply to physician-patient email communications. Physicians who adopt an email communications policy with patients must take precautions to protect patient confidentiality. Federal HIPAA privacy statutes do not specifically discuss email or specify exact safeguards required to protect a patient's health information. HIPAA security regulations do specify, however, that email encryption is an "addressable specification." An addressable specification is a safeguard that is not required, but which must be considered and implemented if reasonable and appropriate. If it is not implemented, the health care organization must convincingly document why it was not deemed reasonable to implement. Other information security issues that should be addressed include password-protected computer access, policies delineating who is authorized to receive emails, Internet firewalls, virus protection, and data backup procedures.

State laws govern medical licenses, as well as medical records documentation and retention. Licensing laws vary from state to state and most do not address the use of emerging technologies such as email communication with patients or telemedicine. However, many states require licensure within their state to render care to patients electronically. Since physician-patient email is a medical record, physician-patient email systems should address compliance with applicable state medical records laws.

### Reimbursement Issues

Reimbursement for email communication with patients is not routine. Although CPT code 0074T facilitates workload capture for email and online consultations with patients, Medicare and most insurers do not reimburse this activity. Published data suggesting that adoption of physician-patient email communication leads to reductions in overall health care costs has spurred a few insurers to reimburse providers for the service. Most physicians welcome these changes. In one study, 69% of physicians said they would increase the use of electronic communication with patients if they were reimbursed for these services.<sup>15</sup> If an insurer does not reimburse for email care, physicians should obtain the insurer's consent before billing patients directly for these uncovered services; direct billing is enforceable only if patients have signed a contract that includes a description of the provider's fees for such services.

“The growing adoption of online electronic medical records provides an opportunity to use linked secure web messaging as an alternative to traditional email communication.”

### Electronic Medical Records

The growing adoption of online electronic medical records provides an opportunity to use linked secure web messaging as an alternative to traditional email communication. The Department of Veterans Affairs has adopted the use of a complete electronic medical record (EMR) since 2000. Now the VA is in the process of providing patients a web-based link to selected portions of their medical record

**“Telephone care will still be used, but perhaps only for urgent or sensitive matters.”**

called “My HealtheVet.”<sup>16</sup> When “My HealtheVet” is fully deployed, it will serve as a secure electronic portal for web messaging between patients and health care providers. It will provide patients with a personalized online educational resource and a personal health record where they can visually track their own health data and progress towards goals. The potential for improving patient satisfaction, patient adherence, self-care practices, and

ultimately health outcomes with a fully integrated web based EMR and web-messaging system are exciting and need to be evaluated in future research.

### **Ethical Guidelines**

Organized medicine and expert panels have published guidelines addressing ethical, legal, and practical issues surrounding physician-patient email communications. The VHA National Ethics Committee Report “Online Patient-Clinician Messaging: Fundamentals of Ethical Practice”<sup>17</sup> recommends that providers: 1) ensure confidentiality and security of communications, 2) ensure equal quality of care for nonusers, 3) avoid depersonalizing

#### **AMA GUIDELINES FOR PHYSICIAN-PATIENT EMAIL USE**

1. Establish turnaround time for messages and exercise caution when using email for urgent matters.
2. Inform patients about privacy issues. Patients should know who besides addressee processes messages during addressee’s usual business hours and during addressee’s vacation or illness.
3. Retain electronic and/or paper copies of email communications with patients.
4. Establish types of transactions (prescription refills, appointment scheduling, etc.) and sensitivity of subject matter (HIV, mental health, etc.) permitted via email.
5. Instruct patients to type the category of transaction in the subject line of the message for filtering, such as, for example, prescription, appointment, medical advice, or billing question.
6. Request that patients put their name and patient identification number in the body of the message.
7. Configure automatic reply to acknowledge receipt of messages.
8. Send a new message to inform patients of completion of request.
9. Request that patients use auto-reply feature to acknowledge reading clinician’s message.
10. Develop archival and retrieval mechanisms.
11. Maintain a mailing list of patients, but do not send group mailings where recipients are visible to each other. Use blind copy feature in software.
12. Avoid anger, sarcasm, harsh criticism, and libelous references to third parties in messages.
13. Append a standard block of text to the end of email messages to patients, containing the physician’s full name, contact information, and reminders about security and the importance of alternative forms of communication for emergencies.
14. Explain to patients that messages should be concise. If email messages become too lengthy or the correspondence is prolonged, notify patients to come in to discuss or call them.
15. Remind patients when they do not adhere to the guidelines. For patients who repeatedly do not adhere to the guidelines, it is acceptable to terminate the email relationship.

Table 1

**AMA MEDICOLEGAL AND ADMINISTRATIVE GUIDELINES**

1. Develop a patient-clinician agreement for informed consent for the use of email.
2. Provide instructions for when and how to convert to telephone calls and office visits.
3. Hold harmless the health care institution for information loss due to technical failures.
4. Waive encryption requirement, if any, at patient's insistence.
5. Describe security mechanisms in place, including using a password-protected screen saver for all desktop workstations in the office, hospital, and at home.
6. Never forward patient-identifiable information to a third party without the patient's permission.
7. Never use patient's email address in a marketing program.
8. Never share professional email accounts with family members.
9. Never use unencrypted wireless communications with patient-identifiable information.
10. Double-check all "To" fields prior to sending messages to ensure accuracy and privacy.
11. Perform at least weekly backups of email onto long-term storage. Define long-term as the term applicable to paper records.
12. Commit policy decisions to writing and electronic form.

Table 2

physician-patient communication, 4) make participation voluntary for both patients and clinicians, 5) inform patients about the risk, benefits, alternative, and terms and conditions of online communication, and 6) limit communication to appropriate uses. The report also encourages health care organizations to recognize online workload. AMA Guidelines for Physician-Patient Electronic Communications are set forth in Table 1 and Table 2.<sup>18</sup>

In summary, physician-patient email communication is an evolving area of medicine whose implementation is being addressed by legal, ethical, medical, and technical experts. It is foreseeable that, with a complete transition to an electronic medical record system, linked forms of electronic communication (email, online-medical record, web-messaging) between patients and providers will become an integral part of the medical work flow, just like the telephone is an integral part of the current paper-based medical practice. It is predicted

that email and web messaging will replace the phone call and paper-based mail for routine tasks like scheduling, reporting test results, providing routine medical instructions and education to patients, and requesting supplies and prescription refills, to name a few. Telephone care will still be used, but perhaps only for urgent or highly sensitive matters. As the overall model of health care delivery evolves from a fragmented paper-based system to an integrated model that utilizes e-health technologies, it is expected that initial barriers like medicolegal issues, confidentiality issues, and the current lack of reimbursement will be overcome by the introduction of both technical innovations and new legislation.

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# LIABILITY FOR EMS FIELD PROVIDERS

BY Harland T. Westgate\*

## Introduction

Modern EMS (Emergency Medical Services) is a young field with ancient roots. Some scholars trace the basic principle of EMS – rapid transport to a treatment facility – back to Roman times. Most agree that the first instance of an organized effort to provide such transport occurred under Napoleon, when he had a unit in his armies tasked with retrieving the wounded from the battlefields and transporting them to the nearest doctor. Given the success of this effort in terms of improved survival rates of injured soldiers, it is somewhat surprising that the concept was not applied to civilian life sooner than it was.



While several ad-hoc attempts at providing basic first aid (or at least transport) began in the civilian United States as early as the late nineteenth century, modern EMS systems were born with the passage of the National Highway Safety Act of 1966, establishing uniform basic training and equipment standards. This Act marked the official arrival of EMS into the national political and governmental consciousness. Advances in treatment techniques for cardiac arrest and basic trauma made it frequently possible to stabilize a patient in the field, minimizing tissue damage from ischemia or unstable fractures and thereby increasing long-term outcomes.

With any service, however, comes the possibility of liability. Federal lawmakers and various state legislatures concluded that the need for an organized EMS system was great enough to warrant protection from most kinds of liability, allowing for sanctions against EMTs (Emergency Medical Technicians) and EMS systems in only the most egregious of circumstances. In some jurisdictions, EMTs are protected by Good Samaritan statutes, and in

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others they are protected by extensions of some form of public duty doctrine or other governmental immunity.

### Case Law

The following cases will illustrate three different approaches to liability protection. The first shows a statutory scheme reflecting Good Samaritan principles; the second a direct and explicit grant of immunity to EMTs within a Good Samaritan statute; and the third shows an extension of the Public Duty/governmental immunity protection that may even have gone too far in precluding liability.

#### Case 1: No Liability For Death Due To An Unsecured Airway

*Bowden v. Cary Fire Protection District*, 710 N.E.2d 548 (Ill.App. 2 Dist., 1999).

In *Bowden*, an Illinois man collapsed in his driveway in front of his son, due to a severe asthma attack. The son called 911 and began cardiopulmonary resuscitation (CPR); later, the son would testify that he observed the chest rise during mouth-to-mouth respirations, thereby establishing that a patent airway existed at the time of the 911 call. Ten minutes after the call was received, the EMTs arrived on scene and directed the son to stop CPR. One EMT questioned the son about Mr. Bowden's condition, and the other went into the residence to obtain his medical history from his wife. This history included one cardiac and two respiratory arrests, all triggered by asthma attacks.

The EMTs assessed Mr. Bowden, finding that he was conscious and breathing shallowly at about 10 times per minute, and that he had a pulse. The EMTs decided not to assist with

ventilations, but did place Mr. Bowden on high-flow oxygen through a face mask. The patient's color improved slightly with oxygen, and the EMTs rechecked his lung sounds and chest rise.

Prior to being placed in the ambulance, the patient's respiratory rate dropped suddenly. The EMTs determined that he required immediate transport to an ER. Although there was some difficulty getting the patient into the ambulance, and Mr. Bowden's son had to help lift the stretcher, the total on-scene time was only 7 minutes (less than the "Platinum 10" minute time standard), which means that all of the above events happened in fairly rapid succession, and that the EMTs were not wasting valuable time.

En route to the hospital, the patient went into full cardiopulmonary arrest. The EMTs contacted online medical control and were ordered to intubate the patient. The intubation attempt failed, despite having stopped the ambulance to make visualization and insertion easier, and the patient vomited. His airway was suctioned and oxygen was administered. Since the ambulance was close to the hospital, the EMTs were ordered not to attempt intubation a second time. The ambulance arrived at the hospital approximately 27 minutes after the 911 call was received, meaning the total transport time was about 10 minutes. The patient was treated in the ER and then admitted, and was maintained on life support until he died eight days later. The official cause of death was status asthmaticus.

The complaint filed by the plaintiff alleged four failures on the part of the EMTs and two on the part of the system. It alleged that the EMTs should have forced oxygen into the patient's lungs immediately on arrival at the scene; that

they should have immediately contacted online medical control for orders to intubate; that they should also have sought orders to administer asthma medications; and that they failed to properly intubate after being instructed to do so. As against the system, it alleged that the system itself failed to provide EMTs that were properly trained and authorized to intubate, or failed to obtain intubation training and authorization for EMTs. Under the plaintiff's theory, taken together all the allegations constituted willful or wanton misconduct.

In Illinois, the EMS Systems Act provides immunity for EMTs performing treatment within their scope of training, even if the treatment is performed negligently. To establish liability, willful or wanton misconduct must be shown. This means that the EMTs must have had an actual intent to harm the patient, or have shown an utter indifference to the safety of the patient.

Additionally, the act or omission must have been committed under circumstances exhibiting a reckless disregard for the well-being of the patient. For example, a situation in which there could be liability would be one in which the EMTs recognized and acknowledged an EKG showing ventricular fibrillation and then did nothing to attempt to treat or correct the condition.

At the trial court, Cary Fire Protection District and the EMTs moved for summary judgment, on the basis that the facts as stated in the complaint, even if true, would amount only to negligence, and not the required willful or wanton misconduct. The motion was granted, and the appeals court agreed. On appeal, the court focused on the care that the EMTs did give, noting that it was fairly comprehensive. Because of this, the court concluded that the

EMTs did not exhibit utter indifference towards Mr. Bowden's health. The court also agreed that if all of the facts in the Bowden's complaint were assumed to be true, the EMTs would be guilty only of negligence, for which they are immune.

Cary Fire Protection District was also found to be immune not only because it was not the entity responsible for training or licensing its EMTs (that falls to the State Department of Health), but also because even if it was, its EMTs are all trained and licensed as required by Illinois law. Since the intubation "certification" is not required by law, Cary Fire Protection District was under no obligation to hire only EMTs who have it. Therefore, there was no possibility that the Fire Protection District could have exhibited willful or wanton misconduct in hiring non-intubation-certified EMTs.

### **Case 2: No Liability For Death After Hyperventilation Treatment Applied To Patient Having An Asthma Attack**

*Tatum v. Gigliotti*, 565 A.2d 354 (Md.App., 1989), aff'd 583 A.2d 1062 (Md., 1991).

The patient in this case had a history of asthma attacks, dating back to the age of three. On the date in question, the patient called 911 and stated that he was having a severe attack. EMTs from the Prince George's County, Maryland, Fire Department were dispatched. At the scene, the EMTs noticed that Mr. Tatum was breathing rapidly, and, thinking he was hyperventilating, attempted to place a paper bag over his face. Mr. Tatum resisted this, so the EMTs administered oxygen instead. They then walked Mr. Tatum to the ambulance, still breathing abnormally, instead of using a stretcher or stair chair. EMT Gigliotti testified that en route he

attempted to administer oxygen by face mask, but that Mr. Tatum resisted. Mr. Tatum apparently held the mask for blow-by delivery, but dropped it when he got up off the stretcher to sit on the bench seat, and at some point slid off the bench seat to the floor, where he was found face-down on arrival at the hospital. The ambulance report for the call stated that upon arrival at the hospital, “Mr. Tatum was conscious, stable, pupils normal, and pupils were equal.” The ER nurse, however, testified that Mr. Tatum was in cardiopulmonary arrest on arrival. The patient later died.

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In Maryland, when a provider is covered by the Good Samaritan statute, the plaintiff must prove gross negligence to recover damages. Gross negligence is defined by the Maryland Law Encyclopedia as existing when a person “inflicts injury intentionally or is so utterly indifferent to the rights of others that he or she acts as if such rights did not exist.” This standard, as applied, is essentially the same as the standard discussed in the *Bowden* case – malice towards or a total disregard for the patient’s health is required.

Under Section 132(a) of the Good Samaritan statute at the time, a provider was covered if they were “licensed by the State of Maryland to provide medical care... [and gives care] for which he charges no fee or compensation...” In this case, the appeals court held that any provider who does not directly bill the patient

for services is covered, even if that provider is a paid employee. To reach this conclusion, the court relied partly on a statement from the Maryland Attorney General that “if the victim is not charged by the one rendering the assistance...even a salaried employee is entitled to immunity.” The court also noted that Section 132(b) of the Good Samaritan statute specifically stated that immunity applied to various agencies whose employees are normally salaried. Therefore, the plaintiff’s contention that immunity did not exist because the EMT’s salary constituted “compensation” under the Good Samaritan statute was rejected.

The court then had to decide if the conduct of the EMTs constituted gross negligence, that is, an utter disregard for the health of the patient. The court determined that the conduct of the EMTs was, at most, mere ordinary negligence, and not gross negligence. The court noted that the plaintiff’s own expert witness would not state that the EMT’s conduct constituted a reckless disregard for Mr. Tatum’s life. While the facts of this case appear more disturbing than the facts of the *Bowden* case, at least in terms of quality of care rendered, the conduct of the EMTs was ruled not to amount to a complete disregard for the patient’s health.

### **Case 3: No Liability Because Failure To Transport Patient Constituted Wanton, And Not Willful, Misconduct**

*Williams v. City of Philadelphia*, 569 A.2d 419 (Pa.Comwlth., 1990).

On June 23rd of 1984, City of Philadelphia EMTs were dispatched in response to a 911 call for a man who had fallen down a flight of stairs. On arrival, the EMTs found Mr. Williams unconscious. They attempted to wake him by

shaking him and using a makeshift ammonia inhalant, but to no avail. When they discovered from the patient's family that Mr. Williams had been drinking before his fall, they decided that he would just "sleep it off" and left the scene. Approximately 4 or 5 hours later, the family called 911 again stating that Mr. Williams was still unconscious. The same EMTs returned, and this time transported the patient to the hospital. Seven days later, Mr. Williams died as a result of a subdural hematoma, determined to have been caused by his fall.

Pennsylvania differentiates between wanton misconduct and willful misconduct. Willful misconduct means that the actor must actually desire to cause a particular result, whereas wanton misconduct means only that the actor had a conscious indifference to the consequences of his actions. Section 8545 of the Pennsylvania Code grants immunity to government employees from liability for their actions in the course of their duties, unless the actions constitute fraud, actual malice, or willful misconduct. To prevail in a wrongful death suit against city-employed EMTs, then, the plaintiff must show that the EMTs acted willfully and wanted the patient to die.

The question for the court here was fairly simple – did the evidence show that the EMTs desired for Mr. Williams to die? The answer was no, although they did exhibit a conscious indifference to his health and safety. Their actions, the court said, constituted wanton misconduct, or a complete and utter disregard for an obvious health risk. Since there was no evidence indicating that they actually wanted Mr. Williams to die, however, they were immune from liability under Pennsylvania law. The question that remains is whether this is the "right" result.

### **The David Rosenbaum Case**

David E. Rosenbaum, a well-known reporter for the Washington Bureau of the *New York Times*, went for a walk in his District of Columbia neighborhood on the evening of January 6, 2006. Later that evening, a neighbor found him in distress and called 911. For whatever reason – perhaps vague information obtained from the caller – a Basic Life Support (BLS) ambulance was dispatched while an Advanced Life Support (ALS) ambulance sat at a hospital just a few blocks away. The BLS ambulance came from across town, 20-some minutes away. The first two units on scene were an engine crew (Firefighter/EMTs) and a police car.

The engine crew later provided written statements to their supervisors, summarized in newspaper accounts, stating that Engine 20 personnel found a patient lying face-up on the sidewalk, in an altered mental status. He was not able to speak. They examined and assessed the patient and found no signs of trauma. Their initial assessment was that he was intoxicated. The police report, however, also quoted in the *Washington Post*, stated that the police officers "found Mr. David Rosenbaum, in a semi-conscious state, bleeding from his head." The police report further stated that Mr. Rosenbaum vomited when the EMTs attempted to rouse him, and the engine crew's report indicated that he vomited numerous times while on the ground. The ambulance report indicated that he continued vomiting on the way to the hospital.

Taken together, these written reports suggest that Mr. Rosenbaum presented with protracted emesis, altered mental status, and bleeding from the head, indicating that he was not a stable patient. Moreover, he scored a relatively low 6 on the Glasgow coma scale. Local

emergency protocols direct that any patient who is unconscious or who has a Glasgow coma scale below 13 and is unresponsive to therapy be designated as a priority one patient.

Nonetheless, the nearby ALS unit was not summoned, as would normally be the case with a critical patient, and he was not transported to the nearest hospital, but instead was transported across town to Howard University Hospital. Mr. Rosenbaum died several days later. Subsequently, the medical examiner's report noted extensive head trauma and injuries to the chest and extremities sustained during a robbery.

**“Whatever the scheme for providing immunity, the purpose is always the same--to enable EMTs to help those in need without having to worry about whether they might be sued over a bad result.”**

Although the EMS care provided has been highly criticized in the local press, no negligence case has been brought to date. Moreover, even if legal action is filed, the Public Duty Doctrine may render the EMS providers immune from liability. As interpreted in the case of *Miller v. District of Columbia*,<sup>1</sup> the Doctrine immunizes emergency personnel unless the plaintiff can show either that a special duty was owed to the victim (e.g., due to repeated patient/provider contacts with the EMS personnel responding, and as opposed to a general duty owed to the public), or that the actions of the defendant “made the condition worse than it would have been had they done nothing at all.” Obviously, no special duty existed toward Mr. Rosenbaum, and it is

arguable whether the EMS providers' actions made his condition worse than if they had done nothing.

### Discussion

Whatever the scheme for providing immunity, the purpose is always the same – to enable EMTs to help those in need without having to worry about whether they might be sued over a bad result. The reason is likewise constant, and that is the assumption that even poor care is better than no care at all in an emergency. This in turn reflects a more important, deeper assumption about the nature of “poor care,” which is that the patient is at least marginally better off with the care provided than he would have been without any care at all.

Exceptions to immunities such as “gross negligence” or “wanton or willful misconduct” reflect this, for when the conduct of the provider becomes dangerous to the patient, the care provided is no longer better than “no care at all.” This danger can come either from purposefully harmful acts (willful misconduct) or from an intentional indifference towards an obvious danger (wanton misconduct or gross negligence). For this reason, perhaps the Pennsylvania statutory scheme, providing for liability only in cases where the EMTs desired for the patient to die, may go too far in granting immunity.

Despite the differences in treatment protocols across various jurisdictions, no competent doctor would allow protocols to be instituted that enable an EMT to fail to transport an unconscious patient whom they cannot rouse. Usually, such a presentation would necessitate an immediate call for Advanced Life Support (ALS) and immediate transport to the closest ER. Ongoing loss of consciousness subsequent

to a fall constitutes a priority patient, and this is not a difficult determination to make. The Pennsylvania court in *Williams* admitted that ignoring this condition was so egregious as to constitute wanton misconduct, a display of complete and utter indifference towards the patient's safety.

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At this point, the providers have effectively done nothing at all for the patient, and so they cannot rightly be said to be “better than nothing.” At best, the care the providers have given is exactly nothing. Considering that providers have a duty to act once they have responded to a call, and that the public looks to EMTs as authority figures, it is much more likely that the failure of the providers in *Williams* was actually more harmful to the patient than had they never responded at all. For instance, had they never responded, the family may have driven the patient to the hospital themselves. Immunity may logically be provided if an EMT attempts to act in the patient's best interests, but it is difficult to fathom why (absent scene safety concerns) a complete failure to act in the face of obviously serious physical findings can or should be protected, as in *Williams*.

## Conclusion

Like physicians and other allied health care personnel, EMS providers have generally been granted the gift of immunity from suit for their good faith actions, in the absence of willful misconduct or gross negligence. The rationale is to encourage the ready provision of emergency care without the fear of lawsuits. EMS providers should understand that the purpose of this immunity is not to countenance substandard care, but rather to encourage the unfettered rendering of medical assistance. Accordingly, both individual EMS providers and EMS systems should continue to aggressively utilize existing quality assurance and quality improvement resources to identify weaknesses and construct remedial programs to strengthen the system. The protection that the law extends to mere negligence by EMS providers can be profitably used to turn those mistakes into opportunities for improvement. In this manner, immunity for EMS providers can serve the public health in two ways: first, it can, as always, encourage willingness to render emergency aid by removing the threat of lawsuits; second, the immunity can enhance quality assurance programs by allowing for the free and open examination of prior EMS mistakes in an ongoing quality assurance effort without fear of liability.

## Reference

1. *Miller v. District of Columbia*, 841 A.2d 1244 (D.C. App. 2004).