**MEMORANDUM**

**TO:** CORDEM

**FROM:** Michael Ramsay, MD, JD

**DATE:** April, 23, 2018

**RE:** Emergency Medicine and the Law: AKA, Can you handle the truth?

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## Issue

Emergency medicine residents are required to cover the Model of the Clinical Practice of Emergency Medicine [1], but this is a heady topic not normally covered in depth in our core clinical reference texts. [2],[3].

We propose and advocate a synergistic approach in presenting this material to our emergency medicine residents by pairing seasoned clinical faculty with legal subject matter experts.[4] This team is then asked to present the core material, and then to use a case-based approach to reinforce this complicated marriage of both clinical medicine and the related legal principles.

## Brief Answer

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[1] https://www.cordem.org/files/DOCUMENTLIBRARY/2016%20EM%20Model%20-%20Website%20Document.pdf

[2] Tintinalli JE, Stapczynski JS, Cline DM, Ma OJ, Cydulka RK, Meckler GD, eds. Tintinalli's Emergency Medicine: A Comprehensive Study Guide. New York, NY: McGraw-Hill; 2011

[3] Marx JA, Walls RM, et al., eds. Rosen's Emergency Medicine: Concepts and Clinical Practice. Philadelphia, PA: Mosby/Elsevier; 2010.

[4] http://www.hli.ualberta.ca/en/HealthLawJournals/~/media/hli/Publications/HLR/11-2-nelsonfrm.pdf

Whether it is the basic understanding of the elements of negligence, or the type of behavior that may result in a tort of negligence, it appears that there is a paucity of understanding regarding medical malpractice.[5] This lack of understanding, or misinterpretation appears to befuddle our learners both in medical school and in residency. [6] Unfortunately, this knowledge gap continues into the practice arena afflicting even clinicians with many years of experience. [7]

"(T)he successful practice of medicine increasingly requires knowledge of its legal aspects. Several developments in the health care environment demand this change: the rise of managed care and provider contracts; escalating malpractice awards and evolving medical liability law; and the growing complexity of the business of medicine." [8]

## Facts

Our approach to this lecture series is in four parts rotating every 18 months.

1) EM and the Law (I): Medicine, Negligence, and Torts. AKA, How to truly scare your PGY 1s on Halloween.

2) Cognitive Errors and Bouncebacks: Top 10 ways to meet your malpractice carrier.

3) Law Enforcement and the Emergency Physician: Worst case scenario, EM style.

4) Good Samaritans, the Law and You: Why you should help at 50,000 feet, despite the offer of another snack mix.

## Discussion

Lecture highlights:

I. EM and the Law (I): Medicine, Negligence, and Torts, or how to truly scare your PGY 1s on Halloween.

A. Introduction to criminal vs. civil or tort law,
B. introduction to negligence,

[5] Bryan A Liang, "Medical Malpractice: Do Physicians Have Knowledge of Legal Standards and Assess Cases As Juries Do?" (1996) 3 U. Chi. L. Sch. Roundtable 59 at 64-65.
[6] Chad D. Kollas, "Exploring Internal Medicine Chief Residents' Medicolegal Knowledge" (1997) 18 J. Legal Med. 47 at 60
[7] *Supra*, note 5.
[8] *Supra*, note 6 at 47.

C. introduction to elements of negligence using the Sercye case [9],
D. PGY 1 liability and negligence using Mercil v. Mathers [10],
E. upper level liability and negligence using Gonzalez [11],
F. and a general overview of common vulnerabilities and general liability pointers.

II. Cognitive Errors and Bouncebacks: Top 10 ways to meet your malpractice carrier.
   A. Dissection of 1-3 negligence cases.
      a. Expert witness SME (Subject matter expert, Clinician, Hospital Counsel, hospital defense counsel, etc. recommended.)
   B. How to approach bounceback patients
   C. Discussion of cognitive biases as it pertains to model clinical practice 20.4.6[12]
      a. 20.4.6 Risk management
         i. 20.4.6.1 Liability and litigation
         ii. 20.4.6.2 Professional liability insurance
         iii. 20.4.6.3 Risk mitigation
         iv. 20.4.6.4 Error disclosure
         v. 20.4.6.5 Root cause analysis
      b. Anchoring vs. Confirmation vs. etc. [13]
   D. Top 10 ways to get to know your malpractice carrier.

III. Law Enforcement and the Emergency Physician: Worst case scenario, EM style.
   A. An in depth look at police interaction with hospital and emergency personnel.
      a. 4th amendment analysis, and search process as it relates to Hippa, and healthcare
      b. Consent, express and implied as it pertains to healthcare.
   B. What to do when faced with a demand WITHOUT a warrant.
      a. EMTALA
      b. Exploration of capacity
      c. Exploration of consent

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[9] **Sercye-McCollum v. Ravenswood Hosp. Medical Center, 140 F. Supp. 2d 944 (N.D. Ill. 2001), US District Court for the Northern District of Illinois - 140 F. Supp. 2d 944 (N.D. Ill. 2001), April 25, 2001**

[10] Mercil v Mathers; No C3-93-140, 1994 WL 1114 (Minn Ct App Jan 4, 1994), rev'd on other grounds, 517 NW2d 328 (Minn 1994)

[11] Gonzalez v St John Hospital & Medical Center, 739 NW2d 392 (Mich Ct App 2007).

[12] https://www.cordem.org/files/DOCUMENTLIBRARY/2016%20EM%20Model%20-%20Website%20Document.pdf

[13] Pat Croskerry, "The Importance of Cognitive Errors in Diagnosis and Strategies to Minimize Them" (Academic Medicine, August 2003).
**http://journals.lww.com/academicmedicine/Fulltext/2003/08000/The_Importance_of_Cognitive_Errors_in_Diagnosis.3.aspx**

d. Shared decision making, and right of refusal considering Schoendorff [14]
e. Battery, conspiracy, criminal solicitation?

C. What to do when faced with a demand WITH a warrant.
D. What is "Obstruction of justice" anyway?
E. Decisional capacity and the impaired patient.

IV. Good Samaritans, the Law and You: Why you should help at 50,000 feet, despite the offer of another snack mix.

A. Exploration of Duty
a. Why Americans hate lawyers.
b. Root of American jurisprudence is Common Law, despite recent textualist assertions.

B. Affirmative duty
C. Elements of a Good Samaritan Act[15]
a. Ordinary v. Gross negligence[16], [17]
b. Exceptions to typical duty of care [18], [19]
c. Billing and Good Samaritans
d. Ethical duty to respond[20]

D. Recap Negligence elements and theory
E. Aviation Medical Assistance Act of 1998 (AMAA)[21]
a. Around the world: Common law vs. Civil law.

1) [14] *Schoendorff v. Society of New York Hosp.*, 105 NE 92, 93 (NY 1914)

[15] SC Code § 15-1-310 (2012)

[16] Draney v. Bachman, 138 N.J. Super. 503, 509- 510 (Law Div. 1976) quoting Oliver v. Kantor, 122 N.J.L. 528, 532 (Sup. Ct. 1939), aff'd 124, N.J.L. (E. & A. 1941).

[17] Jackson v. South Carolina Dep't of Corrections, 301 S.C. 125, 390 S.E.2d 467 (Ct. App.1989), *aff'd*, 302 S.C. 519, 397 S.E.2d 377 (1990).

[18] 12 V.S.A. § 519 (http://legislature.vermont.gov/statutes/section/12/023/00519)

[19] https://www.revisor.mn.gov/statutes/?id=604A.01&format=pdf

[20] Code of ethics of the American Medical Association, Chicago: American Medical Association; 2006.

[21] Aviation Medical Assistance Act of 1998, Pub. L. 105-170, Apr. 24, 1998, 112 Stat. 47, Sec. 5. Washington DC: National Archives and Records Administration, 1998.

## Conclusion

Physicians, emergency medicine trained or otherwise are not legal experts. Due to the nature of the confusing archaic elemental practice of law, and the application of common law theory to laws that impact on our practice, we owe to our learners to give them the basic tools to deal with the pervasive nature of health law on the practice of emergency medicine.

A collaborative lecture series between SMEs in both medicine and law can be systematically laid out to provide all trainees appropriate exposure on a rotating 18-month schedule with a 4-part lecture series. This approach will give most learners the opportunity for exposure once or twice during residency even in the setting of sporadic off-service months.