

CAPSULES

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GOOD SAMARITAN IMMUNITY: WHAT DOCTORS SHOULD KNOW

by Ann Whitehead, Esq.,
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As you enter the nurse's station, a colleague asks for your help to deal with an emergency (e.g., placement of a central venous line or endotracheal tube, or assistance with a Code). You do your best, but the patient dies, nonetheless. The family is distraught and seeks the advice of an attorney. They bring a lawsuit against you, as one of the healthcare providers identified in the medical record. Are you immune from liability for the patient's death? Maybe, if you were acting as a Good Samaritan.

A Good Samaritan is a licensed medical professional who volunteers to help someone in an emergency situation. The help must be provided:

- (1) absent any professional duty or responsibility to care for the patient (i.e., a patient-physician relationship),
- (2) voluntarily, without any expectation of compensation, and
- (3) in a good-faith effort to help.

How does Good Samaritan immunity apply to everyday life? A common example of a Good Samaritan is a physician who comes upon the scene of a car accident and renders aid to a victim. However, if the physician later bills the patient for his emergency services, he waives Good Samaritan immunity and may be held liable for

emergency services that caused harm to the victim. Thus, the physician must truly be a "volunteer" to qualify for the immunity.

In California, the Good Samaritan statutes¹ provide liability protection to licensed individuals who render emergency medical aid to one who might not receive it otherwise. The statutes provide immunity against liability for injury caused as a result of the emergency treatment. The public policy goal of these statutes is to encourage emergency aid. The test for determining the existence of an emergency is objective: whether the undisputed facts establish an exigency serious enough that some action must be taken. However, this immunity from liability does not apply to acts or omissions constituting gross negligence. (Gross negligence is heedless, reprehensible conduct, not a mere failure to meet the standard of care, and punishable by punitive damages.)

What is not a Good Samaritan act? It is not a Good Samaritan act to take care of one's own patient. The physician-patient relationship is "24/7." For example, a physician attending an awards banquet, where his diabetic patient consumes multiple desserts and drinks a bottle of wine, will likely be held responsible for seeing to the patient's medical needs for the ensuing diabetic coma. The fact that the coma was unexpected and the physician is not on-call does not affect the physician's duty to render medical care to his patient.

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**SITUATIONS WHERE
NO PHYSICIAN
SHOULD GO IT
ALONE**

by Gordon Ownby

Accusations against physicians of inappropriate touching can easily – and even innocently – be made. When they are, the follow-up can be quite trying, even when the physician is fully cleared. Adhering to certain protocols can improve one's likelihood of prevailing.

A 33-year-old patient was admitted for gynecological surgery. In his pre-anesthesia evaluation, Dr. A, an anesthesiologist, noted an unremarkable medical history and bilateral breast augmentation with no prior anesthesia difficulties. After surgery, Dr. A noted no apparent anesthetic complications.

The nurses' recovery room narrative entries showed that privacy curtains were open. Noting shivering, the nurse administered Demerol, after which the patient was observed resting quietly. Later, she gave morphine when the patient complained of some pain. The patient transferred to her room after 1-1/4 hours in recovery.

Later that afternoon, however, the patient stated that Dr. A touched her breasts and vaginal area in an inappropriate manner when she was waking from surgery. The hospital staff initiated an investigation. On the next day, the patient spoke to a law enforcement detective.

A social worker's note described the patient as being upset, but within normal limits. The patient told the social worker that she wanted to pursue this because she did not want this kind of thing to happen to anyone else. She also said that a similar event happened to her sister at a clinic several years earlier.

The patient sued Dr. A, alleging negligence, battery, sexual battery, sexual harassment, and intentional infliction of emotional distress.

In her deposition, the patient said that she recalled hearing Dr. A's voice in the recovery room, asking her if she was awake. She also testified that Dr. A, barehanded, touched her right breast in a cupping fashion for several seconds and then did the same thing to her left breast. She claimed that Dr. A went under her gown again with a swiping motion, touching her vagina. She admitted that she was groggy during this time and that she did not report the event until later that day.

Through Medical Board, hospital, and law enforcement investigations, Dr. A consistently denied any such touching. Though Dr. A's privileges were temporarily suspended by the hospital during its inquiry, all investigations closed with no adverse action against Dr. A.

At trial, Dr. A's defense attorney presented evidence that Dr. A was never alone with the patient in recovery. The jury also heard that the patient's skin had been prepped from breasts to knees with Betadine. At the end of the operation, a nurse removed the Betadine soap and placed a sanitary napkin.

The defense attorney then called a psychiatrist to give the most plausible explanation of what happened.

The psychiatrist explained to the jury that anesthetic drugs are disassociative agents, separating pain from consciousness. According to this witness, the plaintiff was already sensitized to perceiving young women as sexual victims, based on her sister's incident. With this as a starting point, the patient then integrated fragments of information to create a story. Specifically, while she was going in and out of consciousness, she recalled hearing a voice and being touched. Her mind, with the history of her sister and still under the influence of the drugs, mistakenly connected



CASE-OF-THE-MONTH

is a regular feature of CAPSULES, the Bulletin, and the Members Only section of the CAP-MPT website www.cap-mpt.com

Comments on Case of the Month may be sent to Gordon Ownby, CAP-MPT's General Counsel, at gownby@cap-mpt.com.

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**GOOD SAMARITAN
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by Ann Whitehead, Esq.,
CAP-MPT Risk Management

How does Good Samaritan immunity apply to hospital emergencies? As described in the first example, Good Samaritan immunity may protect physicians who volunteer in an emergency, even in the hospital. Other examples include the following: (1) an obstetrician enters the LDR where a patient requires an emergent delivery (i.e., delivery is imminent and there are FHT abnormalities), but her attending physician is not readily available. The obstetrician's voluntarily services may be protected by Good Samaritan immunity. (2) A pediatrician is called to the operating room to see a premature infant with poor Apgars. Later, a neonatologist relieves the pediatrician. In an actual case, the pediatrician was found to be a Good Samaritan for the care provided prior to the arrival of the neonatologist. (3) An anesthesiologist is summoned to the ICU, or to the OR, to assist another anesthesiologist with an emergency intubation. If the family sues after the patient dies, the volunteer anesthesiologist may qualify as a Good Samaritan.



How does the Good Samaritan Law Apply to Athletic Events? A physician who volunteers emergency medical aid at a high school or community college athletic event may qualify as a Good Samaritan. This immunity applies both to the care provided at the site of the event for injuries suffered in the course of such event, and also to care provided during transportation of the injured person to a health care facility. In addition to the above conditions (e.g., voluntary acts, no compensation, good-faith, etc.) the physician must employ conservative care, using only resources available at the site of the accident (i.e., no experimental device or therapy), and the accident victim must not object to being helped.

Other things to remember! Begin emergency medical services as soon as possible. After initiating "voluntary" care, a physician should not leave the scene unless care can be turned over to a competent professional. This might mean accompanying the patient to a hospital emergency room before relinquishing the duty of care.

¹Civil Code § 1714.2; Business & Professions Code §§ 2395-2398; Education Code § 49409; Health & Safety Code § 1317

(cont.)
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Dr. A's voice with the touching of a nurse.

The jury unanimously returned a verdict in favor of Dr. A.

The psychiatrist's testimony provided a way for the jury to understand what happened without having to conclude that the patient was intentionally lying. Long before the trial, however, it was the rock-solid evidence that Dr. A was never alone with the patient that brought quick conclusions to the hospital, Medical Board, and law enforcement investigations.

In addition to never being alone with a patient coming out of anesthesia, there are other settings, such as family practice, ob-gyn, and pediatric care, in which using a chaperone or other medical professional is the preferred practice.

After all, "he-said, she said" is never as good as "she-said, *they*-said."



MANDATORY REPORTING OF ADVERSE EVENTS AND HAIS

by Dan Groszkruger, JD, MPH
Consulting Editor

Q. In 2007, must “adverse events” and healthcare-acquired infections (HAIs) be reported to the State?

A. Yes. Effective July 1, 2007, two new laws mandate reporting by hospitals of both “adverse events” and HAIs to the CA Department of Health Services (DHS). Under these new laws, hospitals (not physicians) are mandatory reporters. However, physicians may be brought into investigations regarding the events by the hospital or the DHS.

SB 1301 defines adverse events to include “never events” – 27 events that never should occur in a healthcare facility.¹ These “never events” are grouped into six categories: (1) surgical, (2) product or device, (3) patient protection, (4) care management, (5) environmental, and (6) criminal events. Also, there is a 28th “catch all” event, defined as “an adverse event or series of adverse events that cause the death or serious disability of a patient, personnel, or visitor.”



Hospitals are required to report “adverse events” within 5 days of their discovery, unless the event poses an “ongoing urgent or emergent threat to welfare, safety or health.” In that case the event must be reported within 24 hours of discovery. DHS must conduct an on-site inspection and investigation, the results of which are to be shared with the public. By 2015, the outcomes of investigations will be posted on DHS’s Web site. Failure to report an “adverse event” is a crime.

SB 739 includes legislative findings that 80% of HAIs involve: (1) catheters, (2) central venous lines, (3) ventilator-associated pneumonias, or (4) surgical site infections. DHS will appoint an Advisory Committee to recommend how HAIs must be reported. Effective on July 1, 2007, hospitals must adopt and file a plan for surveillance and control, and provide annual reports. DHS must promulgate new administrative regulations for infection control by January 1, 2008. Violations of the Hospital Infectious Disease Control Program are crimes.

Confidentiality of patient-specific data reported to DHS remains a major concern. For now, it remains unclear exactly what information is to be publicly disclosed.

¹ www.qualityforum.org/projects/completed/sre/

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