Legal Briefs

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Abandonment

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The AANA Practice Committee and the Council for Public Interest in Anesthesia (CPIA) announced that they are conducting a survey and are looking for CRNA input into what is patient abandonment. Some of the responses appeared on the Internet. I was very impressed with some of the personal experiences which CRNAs were willing to share for the betterment of the profession.

Nurse anesthesia is a profession which obviously attracts committed and caring practitioners. The discussion is important because it might provide guidance to members of the profession about what may or may not be appropriate. The Practice Committee and CPIA had looked for comments on lunch or bathroom breaks or turning patients over to other providers in the postanesthesia care unit and recovery room. Interestingly, the most difficult questions, which were raised by commentators, were those which involved not walking away from the operating room, but having to make difficult choices in the hospital between patient demands. Here are some examples:

1. You are working in obstetrics; you start an epidural. Another patient has fetal distress and requires an emergency cesarean section. There is only one surgeon present and you, the only anesthesia provider.

2. You are giving anesthesia to a 10-year-old having his appendix removed when a 3-year-old is brought in with epiglottitis. There are other physicians and nurses available but none are as skilled at establishing an airway as you are.

3. You are giving anesthesia for a routine operation where the patient is very stable. A patient is brought into the emergency room in cardiac arrest. You are the only anesthesia provider. Do you leave your patient and run across the hall to intubate the emergency room victim?

The answers to these questions depend on what is appropriate practice as determined by nurse anesthetists. However, it would be useful to look at how the courts handle this area because it may help focus the discussion. A word of caution: the law can vary from state to state, and there are sometimes specific state statutes. What will be discussed here will be general principles, but these comments cannot be relied on as the law of any state. In addition, there is a federal statute (The Emergency Medical Treatment and Active Labor Act, EMTALA 42 U.S.C.A. §1395dd), which should also be reviewed in specific situations. Many of the decided cases discuss this duty as it applies to physicians. However, the concepts and principles are equally applicable to nurses and nurse anesthetists in particular.

What is abandonment? *"It is the settled rule that one who engages a physician to treat his case impliedly engages him to attend throughout that illness, or until his services are dispensed with. In other words, the relation of physician and patient, once initiated, continues*

until it is ended by the consent of the parties or revoked by the dismissal of the physician, or until his services are no longer needed, and until then the physician is under a duty to continue to provide necessary medical care to the patient." (61 Am. Jur. 2d, *Physicians, Surgeons, etc.*, §234).

Alternatively, the duty has also been expressed as: *"Thus, a surgeon who abandons his patient in a critical stage of disease to a relatively inexperienced, substitute surgeon, without reasonable notice to enable the patient to secure another medical attendant when the giving of such notice is reasonably possible, is guilty of negligence and is liable to the patient for any damages proximately caused thereby."* (61 Am. Jur. 2d, *Physicians, Surgeons, etc.*, §237).

Exceptions to the rule

Despite the legal textbook's statement that it is the "settled rule," the doctrine of abandonment as applied to the medical field is relatively new. Although there are cases many years old, the Supreme Court of Connecticut considered its first abandonment case in 1976 (*Katsetos v Knowland* (170 Conn. 637, 368 A. 2d 172 (Conn. 1976)). The California Court of Appeals wrote in 1979 that *"The concept of patient abandonment is not well fleshed out in the law of this State." (Schliesman v Fisher,* (158 Cal. Rptr. 527 (1979)), and as late as 1994 the Court of Appeals of Iowa stated *"The question* [of patient abandonment] *before us is one of first impression in Iowa." (Manno v McIntosh,* 519 N.W. 2d 815 (Iowa 1994)). Consequently, although it may be the "settled rule," the "rule" is still a developing "concept," and exceptions to the rule are still being thought out.

Whether a particular situation is abandonment is often not black or white. Nurse anesthetists and other healthcare professionals have to use their judgment as to what is appropriate. This is especially difficult when the law is still developing. Let us consider some examples.

Crowe v Provost

In *Crowe v Provost* (52 Tenn. App. 397, 374 S.W. 2d 645), a woman brought her 22-month-old son to a doctor. The child was given penicillin and a prescription for an antibiotic. After a dose of the antibiotic, the mother thought the child's condition had worsened and she returned to the doctor's office. The doctor has already left the office for lunch. The child was seen by the doctor's office nurse who had 25 years of experience as a practical nurse. She called the doctor and told the doctor that the child's condition was unchanged from the time of examination. The doctor advised the nurse that he would finish his lunch and return to the office. When the doctor's office receptionist returned from lunch, the office nurse left for lunch as well. A few minutes later, the child's condition became much worse, the child vomited, and apparently aspirated.

Although the doctor claimed that the child died because of an overwhelming virus infection, the jury found that the nurse should not have left the child. The jury found that if the nurse had been present, she should have been able to maintain the child's airway, and the child would not have died.

Miller v Dore

In *Miller v Dore* (154 Me. 363, 148 A. 2d 692 (1959)), a woman had a due date of May 16, 1956. On Saturday, May 19, 1956, her obstetrician decided that he was physically overworked and left on a fishing trip. Before he left, he made arrangements with another obstetrician to handle his cases during his absence, but he apparently did not tell any of his patients. The plaintiff went into labor while her obstetrician was on his fishing trip, and although she was attended by the substitute obstetrician, she felt that she was not given sufficient notice to find her own substitute.

An interesting aspect of this case is that nothing went wrong. Delivery was routine and the baby was born healthy. What was the damage? The patient claimed that she had had discussions with her obstetrician to assure that she would have an anesthetic when she went into labor. The patient claimed that the substitute obstetrician refused to give her the anesthetic and that she had a much more difficult delivery.

The court quoted a recognized legal text: *"A physician or surgeon who leaves or abandons his patient in a critical stage of disease without reasonable notice to enable the patient to secure another medical attendant, when the giving of such notice is reasonably possible, is guilty of culpable dereliction, of duty, and, if damages are occasioned thereby is liable therefore."*

There was evidence that the obstetrician did not promise the anesthetic. He merely observed that *"Nowadays [1956] they give a mixture of ether and gas."*

Although the court felt that notice had not been given in sufficient time to permit the plaintiff to make alternative arrangements, the court sent the matter back for reconsideration because it was not clear on what basis the jury had made its finding in favor of the patient.

Meiselman v Crown Heights Hospital, Inc.

In *Meiselman v Crown Heights Hospital, Inc.* (285 NY 389, 34 N.E. 2nd 367 (1941)), after the plaintiff

had been kicked in the knee, he developed a fever. The family physician diagnosed a case of grippe, but when the boy did not recover, the father took him to a specialist who ordered immediate hospitalization. The boy had osteomyelitis and was hospitalized for a period of 18 weeks.

The hospital bill amounted to $1,000 [that is not a typo, this was 1931] of which the father was able to pay only $349. Because the father was unable to pay the balance, the hospital discharged the boy from further hospitalization, forcing the father to take the boy home. Not only was the boy discharged inappropriately, he was not advised that he needed further medical attention.

The court stated *"Common sense and ordinary experience and knowledge such as is possessed by laymen without the aid of medical expert evidence, might properly have suggested to the jury that the condition of the boy at the time that he was left without hospitalization and abandoned by the defendants was not compatible with skillful treatment."*

Katsetos v Nolan

In *Katsetos v Nolan* (170 Conn. 637, 368 A.2d 172 (1976)), the plaintiff who was delivering her fourth child went into shock. The obstetrician incorrectly ruled out internal bleeding as the cause of shock and called in an internist who also failed to diagnose a ruptured intrauterine artery. In the midst of the crisis, the obstetrician returned to his office to treat six patients and was not present in the hospital at various crucial times. The jury was given a charge on abandonment to which the obstetrician objected.

The Connecticut court determined that in the State of Connecticut *"we now follow the general rule that in the absence of an emergency or special circumstances, a physician is under the duty to give his patients necessary and continued attention as long as the case requires it, and that he should not leave his patient at a crucial stage without giving reasonable notice or making suitable arrangements for the attendance of another physician."*

Allison v Patel

On the other hand, there are a number of cases in which physicians have been held *not* to have abandoned their patients. In *Allison v Patel* (211 Ga. App. 376, 438 S.E. 2d 920 (1993)), the defendant was a vascular surgeon whose patient required an arteriogram. The radiologist would only perform it in the presence of a vascular surgeon because of possible complications which might result. Immediately after the arteriogram, the defendant received a telephone call from his brother-in-law who told him that the defendant's mother-in-law had slurred speech, was nonresponsive, and was dying. The defendant left so as to assist his mother-in-law, leaving his patients to be covered by another doctor who was qualified to handle 90-95% of the complications arising from an arteriogram.

The complication which affected the plaintiff was very unusual, and it required the services of a vascular surgeon. Since the defendant was out of town and unreachable, the substitute doctor arranged for the plaintiff to be transferred to another facility where a vascular surgeon was available. The patient received several thrombectomies over the period of a month but suffered cardiac failure while he was in intensive care.

The patient's widow sued on the grounds that the original vascular surgeon deviated from the standard of care by leaving the hospital and failing to make alternative arrangements. The vascular surgeon offered evidence of justification for his absence. The plaintiff argued that under the law, abandonment was abandonment and justification was irrelevant.

The court held that justification *was* relevant because physicians were liable only for *"unwarranted abandonment"* of the patient or for abandoning the patient *"without reason,"* and the jury could *"consider all the attendant facts and circumstances which may throw light on the ultimate question"* as to whether the patient was abandoned.

Manno v MacIntosh

In *Manno v MacIntosh* (519 N.W. 2d 815 (1994)), the defendant was a gastroenterologist who was out of town for 5 days attending a medical seminar. During his absence, one of his patients was determined to need the removal of a diverticulosed colon. The patient's family claimed that the gastroenterologist should be liable because he abandoned the patient.

The court wrote *"to prove abandonment a patient must prove more than a mere termination of a patient-physician relationship... there must be evidence that the physician has terminated the relationship at a critical stage of the patient's treatment, the termination was done without reason or sufficient notice to enable the patient to procure another physician and the patient is injured as a result thereof."*

In this case, the court held that the plaintiff had failed to provide sufficient evidence to create a jury question as to whether there was any intent to abandon the patient. First, the gastroenterologist arranged for an appropriate substitute so the patient was never without medical care. In addition, the doctor had written a lengthy summary note for the substitute to use as a plan for therapy. In the

doctor's absence, the substitute determined that a laparotomy was necessary and scheduled the surgery immediately. On his return from the medical convention, the gastroenterologist immediately resumed care of the plaintiff.

Johnston v Ward

In *Johnston v Ward* (288 S.C. 603, 344 S.E. 2d 166 (1986)), a woman was brought to the emergency room after an attempted suicide. She either neglected to disclose or lied about the precise drugs that she had taken. The emergency room physician transferred her care to a psychiatrist. Instead of coming to the hospital, the psychiatrist arranged for another physician to look in on the plaintiff. The psychiatrist called at various times during the day and was told that the patient was progressing satisfactorily. At about 5:00 p.m., the patient had a seizure. At the same time, her husband discovered that she had overdosed herself with aspirin. She went into a coma from which she did not recover. The patient's estate claimed that the psychiatrist abandoned the patient by failing to appear at the hospital.

The court held that *"where a physician for one reason or another is temporarily unable to attend the patient personally, the physician, without being viewed as having either abandoned or neglected his patient, may make provision for a competent physician to attend the patient.... In the absence of negligence in making the substitution, the physician is not liable for injuries resulting from the substitute physician's want of skill or care unless the substitute physician is in his employ or is his agent or partner."*

Some insight

Note that what is at issue in these cases is not a technical requirement. The name of the topic, "abandonment," provides some insight. The courts might have called this "unauthorized termination," but they chose a word with connotations of "wicked" and "evil." Intent plays a role. In the worst cases, the physician or nurse is absent because of a purely selfish, personal motive. In *Crowe v Provost,* both doctor and nurse left the patient unattended so that they could have their lunch. In *Meiselman v Crown Heights Hospital,* a severely damaged patient was discharged from institutional care because the father was unable to pay the bill. In *Katsetos v Nolan,* the obstetrician left to conduct his routine office visits. On the other hand, in *Allison v Patel,* the physician had to deal with a family medical emergency. In *Manno v Mitchell,* the physician was attending a medical seminar [even if the court failed to note that it was January and the doctor was attending a seminar in Arizona] and showed his concern for the patient by leaving detailed notes.

The courts have made clear that there are no absolutes; professional judgment must be considered in at least three areas. All of these areas can and should be discussed by nurse anesthetists.

1. *Excuse or justification.* The courts are much less likely to find excuse or justification when the reason is purely personal such as lunch or talking to your stockbroker than they are when it is a result of less selfish reasons, such as caring for another patient in an emergency. What is an emergency? Under what circumstances should 8-hour operations be done in facilities with one anesthesia provider?
2. *Competent substitute.* Simply walking out on an anesthetized patient is obviously irresponsible, but are there reasonable substitutes (physicians or perhaps other nurses) who could handle some aspect of the anesthetic in an emergency?
3. *Critical junction.* What parts of the anesthetic process are a "critical junction"? At what point may competent substitutes be found for some aspects of the process? As the AANA Practice Committee and CPIA asked, is this the postanesthesia care unit or the recovery room?

Additional considerations

There are some additional considerations which must be considered in a decision. Patients have given their informed consent to anesthesia. Is it conceivable that *any* patient would consent to an anesthetic if told that the anesthesia provider could be called away in the middle of the anesthetic to treat someone else? Thus, if the anesthetist makes a determination that he or she may safely leave the patient in another's care so that the anesthetist may handle an emergency, the decision had better be correct.

The Emergency Medical Treatment and Active Labor Act now requires that a hospital must provide either medical examination or treatment as may be required to stabilize the patient's medical condition or for transfer to an appropriate facility; provided, that the medical examination or treatment must be within the staff and facilities available at the hospital. Under this Act, can a nurse anesthetist refuse to provide emergency treatment because he or she is engaged in giving an anesthetic to another patient?

Nurse anesthetists expect too much from lawyers. The answers to these questions cannot be provided by lawyers but by nurse anesthetists. If you have ideas or opinions, write or call Sandra Tunajek, CRNA, BA, AANA Practice Director, (847) 692-7050, ext. 303.