A Message from the President

Time moves very quickly. It’s the spring edition already! I hope you found AHRMNY’s Evening Conference both enjoyable and instructive. Our June Full Day Educational Conference will be held on the 22nd. We have many interesting topics and excellent speakers planned. Please make every effort to attend. I’m sure you’ll find it worthwhile!

By the way, I recently read a book by Ronald P. Culbertson, entitled *Is Your Glass Laugh Full?* I highly recommend it to all of you. A sense of humor is especially important for us and our clients in the medical or legal field. As Winston Churchill said, and Mr. Culberson writes, “It is my belief; you cannot deal with the most serious things in the world unless you understand the most amusing.”

Finally, I want to thank my Board of Directors for their outstanding work. They continue to devote many selfless hours to improving and strengthening our organization so we can provide the support that is so necessary to the healthcare risk management professionals of New York.

Alan H. Lieber, Esq.
President

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REFUSAL OF CONSENT IN OBSTETRICS: DOES NO MEAN NO?

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It’s 11:30 p.m. Laura Pemberton presents to the Emergency Room in active labor since 2:00 a.m., dehydrated, requesting an IV which she can take with her to deliver her baby at home. Upon examination, it is discovered that she had a prior cesarean delivery 15 months ago which utilized a vertical incision extending up into the thickened myometrium. However, Ms. Pemberton does not want another cesarean delivery, and has been proceeding with a home birth attended by a midwife since no obstetrician in the state would agree to deliver her by VBAC. When advised that she is facing a significant risk of uterine rupture and her term fetus will most likely die without a cesarean section, Ms. Pemberton states that she does not believe in unnecessary cesarean sections and reiterates that she only wants an IV to bring home. The obstetrician treating her notifies hospital officials who seek an emergency court order to compel Ms. Pemberton to proceed with a cesarean section. A healthy baby boy is surgically delivered the following day.

The foregoing is not a scene from Grey’s Anatomy or ER. It is an actual case which was decided by a Florida District Court in 1999. It demonstrates a rare but troubling situation faced by doctors and hospital quality assurance personnel when an obstetrical patient in extremis refuses treatment. Much has been written on this topic, yet it remains a difficult and complex issue for which there is no clear answer. Patients’ rights to self-determination, fetal rights and protection of fetal interests, the duties and obligations of physicians, and the practical limitations of our judicial system in considering urgent life or death medical issues are all involved. The trend in both law and medicine has been moving away from judicial intervention and toward respecting the autonomy of the competent adult patient to make all treatment decisions. As valid and well-reasoned as this approach is, its unfortunate end result is often maternal or fetal demise or grave injury. On the other hand, prior decisions in which courts intervened to save lives under emergency circumstances are shocking in the complete lack of Constitutional safeguards and due process which they have afforded the patient. Many court decisions in this area involve the administration of blood and cesarean sections and have been very inconsistent, most courts limiting their decisions to the specific facts before them, being hesitant to create any bright line rules for future guidance.

It is, perhaps in response to a number of court decisions in which pregnant women were subjected to medical treatment against their will, that the American College of Obstetricians and Gynecologists (ACOG) put forth Committee Opinion No. 55 in October of 1987, which specifically addressed the issue of patient choice in maternal-fetal conflict. The opinion concluded that “every reasonable effort should be made to protect the fetus, but the pregnant woman’s autonomy should be respected” and “resort to the courts is almost never justified.” Similarly, the American Academy of Pediatrics took the position in 1999 that a physician should not even try to persuade a pregnant woman to change her mind about a refusal of treatment in most cases, and only in rare circumstances should court intervention be utilized as a last resort. In the January 2004 opinion “Patient Choice in the Maternal-Fetal Relationship,” ACOG concluded: “occasionally a woman’s autonomous decision will seem not to promote the beneficence-based obligations (of the woman or the physician) to the fetus. In this situation, when there is insufficient time to obtain transfer of care, the obstetrician must respect the patient’s autonomy, continue to care for the pregnant woman, and not intervene against the patient’s wishes regardless of the consequences.”

These guidelines, which recommend a near absolute deference to maternal autonomy, have been criticized as being oversimplified, not accounting for possible exceptional circumstances, and disregarding the physician’s obligation to the fetus. As noted in a recent survey of maternal-fetal medicine directors, they also seem to represent a “disconnect” from the actual opinions and practices of physicians faced with such complex emergencies. The 2003 study by Adams, et al found that although 95% of those surveyed stated a general agreement with the deference to maternal autonomy espoused by ACOG,
43% stated that a physician could not accept a woman’s refusal of cesarean delivery in cases of well-documented placenta previa, 21% felt that emergency coerced cesarean delivery to prevent serious harm to the fetus could be justified and 48% agreed that there are no morally relevant differences between newborns and near term fetuses. Unfortunately, the case law in this area is equally conflicted.

A 1990 District of Columbia case involving a compelled cesarean section of a premature infant to a terminally ill mother said that the informed decision of a competent adult patient to refuse treatment will control in “virtually all cases.” However, the court specifically declined to overturn a previous decision in the same jurisdiction in which a compelled cesarean section was performed to save the life of a term fetus. A 1996 Connecticut case involving a post-partum hemorrhage held that the hospital had no right or obligation to thrust unwanted medical care on a competent adult patient. However, the court specifically noted in its decision that it was not faced with and therefore did not decide the issue of whether a pre-delivery transfusion to save the life of the baby would have warranted a different result. In 1994, an Illinois court stated that a transfusion was a relatively risk-free and non-invasive procedure, and in 1997, the same court specifically disagreed with this statement. In 1996, a state court in Florida held that a hospital lacked standing to seek a court order for an emergency transfusion based upon Florida’s procedural requirements, but a 1999 Federal Court in Florida denied a patient recovery after a court-ordered emergency cesarean section was performed upon her. A Michigan Court in 1991 concluded that the emergency nature of a post-partum hemorrhage warranted a transfusion without consent despite a prior refusal of blood, whereas a New York Court in 1990 held that obtaining a court order to administer a transfusion in the same situation had been inappropriate, and that the emergency doctrine did not apply where there was a prior refusal of treatment.

The few conclusions which can be drawn from the cases are as follows. The law is clear that a competent adult has the right to refuse medical treatment assuming there is no contrary compelling State interest. The law is equally clear that a parent cannot refuse lifesaving medical treatment for her child who is under the age of consent. Where a pregnant woman with a viable fetus wants to withhold necessary medical treatment, without which either she or her unborn child or both may not survive, the case law is inconsistent at best, particularly where less invasive treatment such as transfusions is concerned.

Equally unhelpful are the guidelines put forth by medical organizations which discuss well-reasoned theories, but which are inflexible and may fail to reflect the actual practice among clinicians faced with a pregnant woman about to die. However, the reasonable consensus appears to be that courts are ill equipped to handle decisions in cases of obstetrical emergencies and that seeking court intervention is usually inappropriate. It seems that the reality of the situation is that most physicians will do their best ethically to persuade their patients to consent to lifesaving treatment, but few will resort to the court. When refusal of treatment cannot be avoided, documentation is the practitioner's last resort. To facilitate documentation, the hospital should maintain specific pre-printed refusal of treatment forms regarding cesarean sections, blood transfusions and other common obstetrical therapies which include the specific risks of not agreeing to the treatment in question and an acknowledgment which clearly states that the patient has been advised of and understands these risks. These forms should be reviewed with hospital counsel and risk managers and available in all emergency rooms and labor and delivery areas, clearly named so that they can be quickly found. A general refusal of consent form should always be available in the event no specific form applies to the situation in question. Not only should these forms be executed, but the treating physician should have at least one other health care provider present for a thorough discussion of the risks of refusing treatment and that conversation should be documented by both the physician and the witness (in addition to the execution of the consent forms).

With respect to the substance of the practitioner’s note, “risks and benefits discussed and patient refused to consent to cesarean section” is not adequate. The result of a note like this is that the physician will testify in detail regarding what risks and benefits were discussed, perhaps based upon her custom and practice or even a specific recollection, and the patient will deny that she was told any or all of those risks. Then, it is up to a jury to decide...
whether to believe what the doctor says or what the patient says. A contemporaneous detailed note is required indicating in clear language that the patient was told and understood the results of what her failure to agree to the necessary treatment would be, preferably with at least one witness to the conversation. Direct quotes may be utilized, particularly to document what the patient said. Another possible approach would be to read the pre-printed refusal of consent form directly to the patient and to document that.

The more difficult documentation situation will occur wherein the patient withholds consent for a period of time, but ultimately agrees to the treatment. This is most likely to occur in the case of an emergency cesarean section, and is particularly problematic because in any subsequent lawsuit for damages arising from the delivery, the timing of the cesarean section will always be the key issue. Of primary importance is, of course, immediately performing the surgery once consent has been obtained. With respect to documentation, the same principals apply as noted above, but accurately timed and detailed notes are even more essential.

It might be impossible, practically speaking, to document every aspect of medical treatment this carefully, but the refusal of treatment in an obstetrical emergency is a seminal event and must be treated as such. Even though documentation alone cannot prevent every lawsuit, in some cases it may, and in those where the lawsuit is brought, it will certainly facilitate its defense.

Conclusion

The rare case wherein an obstetrical patient refuses to consent to necessary treatment presents a complex ethical and legal situation for the doctor and hospital charged with her care. Although in the past, courts were quick to intervene in an attempt to save the life of the mother and/or the fetus, the current trend is away from court-ordered obstetrical interventions. Nonetheless, the law in this area remains inconsistent and unsettled, and provides limited practical guidance. For those unfortunate cases where a refusal cannot be avoided, the practitioner’s last recourse is documentation.

8 Vega v. Stamford Hospital, 674 A.2d 821 (Conn., 1996).
12 Schloendorf v. Society of New York Hospital, 211 N.Y. 125 (N.Y., 1914) (overruled on other grounds by Bing v. Thunig, 2 N.Y.2d 656 (N.Y., 1957)).
15 This could probably be most easily accomplished by storing the forms electronically and printing them as needed. However, if hard copies of the forms are maintained, they should be well organized and easily accessible.

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