Medicolegal Aspects of EM

Duty of care
Primary responsibility to patient
Legal obligation to conform to a particular standard of conduct for the protection of others against unreasonable risks. This includes duty to remain current & competent in field of work.

Negligence
Negligence is based on there being breach of a duty of care where reasonable care (standard expected of the average practitioner of the class to which he belongs in those particular circumstances) has not been provided. The breach of duty of care must have been foreseeable & carry the likelihood of physical or quantifiable harm.

Good Samaritan Acts
Good Samaritan acts are not legally mandatory; however they may be morally, ethically or professionally obligated. Once done there is duty of care & thus subject to laws of negligence.

Medical Ethics
Autonomy: right of patient to make decisions on their own behalf
Beneficence: duty to do best for patient
Non-maleficence: duty to do no harm
Justice: fair distribution of resources, responsibility of wider community
Dignity: the patient (and the person treating the patient) have the right to dignity.
Truthfulness and honesty

Consent
Must be informed, specific, freely given with no undue influence; opportunity to reflect/ask questions
Must cover what is to be done (clear, accurate, relevant info given re: treatment options, foreseeable consequences and SE’s, consequences of not proceeding with treatment); provided by doctor responsible or suitable delegate

Process for consent
Give information
Discuss
  do you comprehend
  recall and paraphrase info
  tell me what you believe is wrong with you now
  do you believe you need treatment
  what treatment has the doctor recommende
  what will the treatment do if you accept it
  why will it have that effect
  why do you think the doctor has recommended this
  what will happen if you don’t have the treatment
  what alternatives are available and what are the consequences of them
  what have you decided, why have you decided this
  what was important to you in reaching this decision
Document
Don’t need consent:
  public health issue (high risk communicable disease (eg. TB))
  mental illness who pose danger to self or public

Implied consent
Patient presents for treatment, willing participant (eg holds out arm for blood test)
Other sources of consent
Parents if married
Mum or Dad if separated as per court order
Legally appointed guardian
Local authority designated in care order/emergency protection order/judicial order
Power of attorney

ED patients that may not be able to consent
Children and adolescents
Intellectually impaired
Mental health patients
Patients under the influence of drug and alcohol
Critically unwell patient

Competence
Determination of mental capacity for decision making
Requirements for competence/capacity to consent
Must be able to receive info (awareness, orientation, memory, attention)
Be able to process and understand medical condition, options for treatment, what is recommended, potential adverse outcomes, likelihood of these, alternatives and their risks and benefits, prognosis if treatment not accepted
Be able to accept information as reality
Be able to maintain and communicate choice (choice should be stable over time without rapid swings)
Be able to manipulate info in rational fashion

Not competent to consent - Implied Consent
A reasonable person would give consent in that situation
Condition is an emergency: attendance at ED implies consent for reasonable treatment
Consent can be assumed in this situation unless evidence that patient would have withheld consent
Can be withdrawn at any time, even if treatment regarded as life-saving by doctor
Cannot be provided by relatives (unless they hold power of attorney) – relatives can provide info on patient’s wishes, beliefs, usual behaviour (substituted judgement, 70% accurate)
Treat intoxication/drug ingestion under implied consent, not mental health legislation

Involuntary detention (mental illness)
Statutory authority to restrain patient if considered to be a risk to themselves/ others
Police have authority to detain and bring to ED any patient they are concerned may be at risk
Do if:
- appears mentally ill
- mental illness requires immediate attention that cannot be given as OP
- patients health / safety or that of others at risk
- patients has refused consent or is incapable of giving consent
- patient cannot receive treatment in a less restrictive manner

Compulsory Assessment and Treatment (Mental Health Act 1992)
Section 8A: request for admission; any adult who has seen patient within 3 days and believes them to be suffering from mental illness
Section 8B: recommendation by qualified doctor who must have examined patient that make them believe there to be mental illness requiring this
Section 9: psych assessment and examination by psychiatrist or other authorised doctor
- admit for assessment and trt for 5/7
- can then do 2nd period of 14/7 (section 13)
- if still need further after this, application to court for Compulsory Trt Order (section 28)
**Physical restraint**
Adequate, trained staff; limits dose of chemical restraint and SE’s; do not use without chemical sedation as risk of injury, rhabdo, ethics; explain to patient and family what you are doing; keep head elevated to prevent aspiration; 5 staff members, one per limb; once restrained, offer meds if refused, give IM/IV; regular obs/monitoring; doctor review Q30mins to reassess need for restraints; safe environment, adequate communication, body language; personal protective gear; temporary measure only; shackles can be used temporarily; seclusion rooms

**Chemical restraint**
Benzos 1st line; PO preferred; 10mg diazepam / 2mg lorazepam PO - 0.5-5mg IV midaz to max 100mg
Antipsychotics: olanzapine better tolerated than haloperidol; 5-10mg olanzapine PO - olanzapine 10mg IM, 2.5-5mg haloperidol IV; avoid droperidol and haloperidol if prolonged QTc; avoid olanzapine if PMH dementia
Maintenance therapy: 1-2mg lorazepam TID, 5-10mg olanzapine TID
Endpoint – calm and co-operative patient
Monitoring important
SE’s: decr RR, aspiration, sudden cardiac death, decr BP, dystonic reaction (eg. Haloperidol), NMS, anticholinergic, delirium, seizures, long QTc, VT

**Advanced care directives**
Should specify circumstances that will activate it and actions that should occur if patient incapable of providing consent
Directive must have been made by the patient voluntarily and while competent
Invalid in suicide attempt

**Paediatrics**
<16 yrs, usually considered to be incompetent
Parent/guardian have power of consent
If parent not available treat by implied consent
Life saving treatment can be given despite parent objections (guardianship agencies involved)
document efforts taken to get consent
get 2nd opinion for another doctor to back you up
eg Jehovah witness - proceed with transfusion, document that needed to sustain life
Mature minor (>14yrs): consent if mature enough to understand, beneficial/non-elective treatment, low risk

**Confidentiality**
Ethical, professional and legal obligation not to disclose to any third party any information acquired in the course of a professional relationship with the patient, without that patient’s specific and voluntary consent.

**Mandatory Reporting/Public Interest - exceptions to confidentiality (statutory disclosures)**
Notifiable diseases
Venereal diseases (STDs)
Coroner cases
Registration of BMD
NAI
Firearms legislation
Impaired healthcare practitioner
Patient Safety

Common Safety Problems
Patient identification errors
Hospital acquired infection
Incorrect interpretation or failure to follow up pending investigations
Medication errors
Communication errors
Physical care errors
Triage errors

Improving Safety in ED
Understand the environment
Identify specific risks
Promote reporting of adverse events and near misses
Analyse and evaluate risks
Treat the risks
Monitor and review
Communicate and consult