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INSIDE

Is Psychiatric Boarding an Unconstitutional Necessity?

By Hon. Nathaniel Schlicher, MD, JD, FACEP, Associate Director, TeamHealth Patient Safety Organization; Regional Director of Quality, TeamHealth Northwest; Emergency Physician, St. Joseph's Medical Center, Tacoma, WA

Psychiatric boarding is the quaint term for the long-term warehousing of the mentally ill in EDs and medical wards, which is the result of a lack of adequate mental healthcare resources in the United States. The Great Recession reduced expenditures on mental health by billions of dollars, pushing an already-depleted system to the breaking point.[1]

In turn, practitioners turned to boarding, starting care in theory in the ED while waiting for a bed to become available.

Unfortunately, many of these patients increasingly were held for days, months, and even nearly a year in EDs and medical wards while awaiting the mystical inpatient psychiatric care bed.

Thousands of Americans depended on this crutch to care for their loved ones, frightened of what would happen if they were turned away. But what would happen if it was now illegal to warehouse patients? Would EDs discharge patients to the street? Would resources that had been missing for years and cost hundreds of millions of dollars appear suddenly? What would the providers be able to do legally when caring for these patients? In 2014, Washington state decided to figure all this out on the fly with a legal grenade.

> PSYCHIATRIC BOARDING IS THE RESULT OF A LACK OF ADEQUATE MENTAL HEALTHCARE RESOURCES IN THE UNITED STATES.

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Customer.Service@AHCMedia.com
AHCMedia.com

EDITORIAL EMAIL ADDRESS:
Jonathan.Springston@AHCMedia.com

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EDITORIAL/CE DIRECTOR: Lee Landenberger
EXECUTIVE EDITOR: Shelly Morrow Mark
ASSOCIATE MANAGING EDITOR: Jonathan Springston
PHYSICIAN EDITOR: Arthur R. Derse, MD, JD, FACEP
CONTRIBUTING EDITOR: Stacey Kusterbeck

Facts of the Case

Washington state created a unique mental health detention process compared to most states. In contrast to the normal physician detention, or "pink slips," used in many states, Washington uses Designated Mental Health Professionals (DMHPs), agents of the county who make detention decisions.

These individuals, generally social workers, consult after the initial physician evaluation and process the first 72-hour detention. Then, they advocate in front of an administrative law judge for an extension to a 14-day hold. When a bed is not available, they assign a patient to a Single Bed Certification (SBC) that for purposes of the state's bed certification requirements converts a medical bed in an ED to a psychiatric bed. This, despite no change in the resources and the fact that many of these beds exist in critical access hospitals without psychiatrists, orderlies, or other mental health resources.

In February 2013, the public defenders who represent detained patients filed a petition against the State of Washington and Pierce County, arguing on behalf of their clients that they were being held illegally under the SBC program without hope for psychiatric treatment. They alleged, and the state agents agreed for the most part, that care in the SBC locations was not to the level of care patients would receive in an evaluation and treatment center or psychiatric hospital bed.

Unconstitutional Deprivation of Liberty

A court commissioner who heard the case found that the practice of psychiatric care was unconstitutional.[2] The Pierce County Superior Court affirmed the decision in June 2013. The case was appealed and expedited to the state Supreme Court.

The civil commitment process requires that a person who is detained and thus deprived of their civil liberties receive treatment that "will give each of them a realistic opportunity to be cured or improve his or her mental condition."[3] Failure to have adequate resources, in fact, is not a rational reason to warehouse patients, according to the court.[4]

The court ruled that the practice of SBC to a non-psychiatric facility did not give the patient a realistic opportunity for cure or adequate treatment to warrant the deprivation of civil liberties for involuntary treatment. As a result, the court, in effect, made the practice of psychiatric boarding unconstitutional.

The initial ruling required that within 20 days, any patient not in an approved psychiatric bed could not be detained for mental health treatment involuntarily.

Although the appellants were satisfied with the decision to make the practice unconstitutional, they feared for the patients' safety with the court's initial proposed timeline of 20 days for remedy to such a complex medical issue.

Addressing hundreds of millions of dollars in backlogged physical bed capacity, understaffed mental healthcare teams, and generalized lack of coverage could not be resolved that quickly. As a result, the state, in concert with the appellants, requested and were granted a 120-day stay of implementation to address the problem.

In so doing, the appellants identified 120 beds of increased capacity that they could bring online in that time to address the court's concerns.

Legislative Remedy

The legislature elected to intervene during its next session, both helping and hurting the cause. Positively, the legislature recognized the lack of funding and invested $100 million over the next two years to add capacity, improve staffing at state facilities, and pay for an outpatient involuntary treatment program.[5]

Unfortunately, the legislature decided to create a new SBC process that requires hospitals to attest to their ability to provide psychiatric care in a non-psychiatric bed to meet the constitutional requirements.[6]

Although this increased the care provided to patients and restored the ability to detain patients when there was a lack of beds, it created another temporary fix without ongoing enforcement.

Contempt of Court

As many expected, the practice of psychiatric boarding returned shortly to the state, despite increased resources. Practice habits essentially have risen to levels previously seen.

In an interesting twist, the county court commissioner who heard the initial suit held a hearing in June. In that ruling, he deemed the state hospital CEO and the executive director of Optum, the county mental health provider, to be in contempt of court and ordered them to jail if they did not admit a patient on an SBC.[7]

One week later, the Pierce County Superior Court overturned the ruling and stayed all further contempt of court hearings until the state and Optum created a plan to resolve the resource issues.[8]

The parties currently are working on a plan to address the capacity issues, but a rapid resolution is not expected. Regardless of the future, the possibility of bloviating administrators and failing regulators going to jail makes even the most cynical physicians smile a little.

Fighting Psychiatric Boarding

No practicing physician enjoys the art of psychiatric boarding, but the remedies often are very expensive and outside of our control.

THE IDEA THAT WE MUST TURN AWAY A PATIENT IN A TRUE PSYCHIATRIC EMERGENCY DUE TO LACK OF CAPACITY GOES AGAINST EVERYTHING ELSE WE DO IN MEDICINE.

The possibility that providers and patients collectively could challenge the practice of psychiatric boarding as unconstitutional to advocate for expanded resources is a tantalizing idea.

Although each state has different civil commitment laws, the underlying fundamental concept of deprivation of liberty and the case law upon which it is based is federal in nature.

Thus, the remedy for unconstitutional deprivation is in play under federal law and it will depend upon the individual case and interplay with the state law on SBC to determine if a legal challenge would benefit clinicians and their patients in each care location.

In Washington, the state medical association and the state chapter of the American College of Emergency Physicians joined an amicus curiae brief in support of the patient appellants to help advocate for additional resources.

For patients, this ruling presented in its initial form a substantial risk: Patients presenting with grave disability and real potential for self-harm or harm of others could be discharged to the street with no resources despite meeting involuntary detention criteria. The risk to the patient is all too real in these circumstances.

We've seen these tragedies play out in the news, such as the attack on a Virginia state senator by his son after no bed was found in the community and he was discharged to the street.[9] Virginia's solution was to mandate the state hospital take the patients in the future if no beds were available in the community. Given the national shortage of beds, the likelihood that this will be a long-term solution remains small.

The idea that we must turn away a patient in a true psychiatric emergency due to lack of capacity goes against everything else we do in medicine. Yet it is the real risk that our patients confront if the practice of psychiatric boarding is found unconstitutional and the practice prohibited.

Provider Risk: Unlawful Detention?

The questions of provider liability and criminal risk for possible unlawful detention and false imprisonment

were not litigated in this case, but are concerns of many providers. In the instance in which psychiatric boarding has been declared unconstitutional, can the provider be exposed to liability if it holds a patient pending a bed availability? The answer is unclear.

Arguably, when acting under the auspices of the Involuntary Treatment Act (ITA) as written with the single bed certification, the answer likely is no.

However, the existence of an illegal law is not an absolute bar to liability or prosecution, but a defense. Thus, one can imagine the possibility of litigation, even if the eventual outcome would be a finding for the physician. This is a risk that leaves many uncomfortable with the current SBC in Washington.

However, if a provider, in the setting of no beds and no SBC authority, were to hold a patient without psychiatric treatment under an ITA statute, there is the possibility of legal action.

That said, most attorneys would agree that doing what is right for the patient and providing care likely is the most prudent step until case law on the point exists. Put another way, I'd rather go down in history as the doctor who did the right thing for my patient, but had the precedent set against me that said doctors have to release floridly psychotic patients to the street due to lack of treatment space. It would not be a fun experience, but in the interests of my patients, it's one I'd be willing to live through. Of course, if you find yourself in that position, be sure to consult your legal counsel.

Conclusion

The decision by the Washington Supreme Court to declare the practice of psychiatric boarding unconstitutional presents a novel approach to fighting the practice and advocating for our patients. However, in doing so, the court created new avenues of risk for providers and put patients in harm's way if the court eliminated the practice of psychiatric boarding without adequate resources in place.

MOST ATTORNEYS WOULD AGREE THAT DOING WHAT IS RIGHT FOR THE PATIENT AND PROVIDING CARE LIKELY IS THE MOST PRUDENT STEP UNTIL CASE LAW ON THE POINT EXISTS.

Time will tell if other states, providers, or patients explore the questions of constitutionality of psychiatric boarding. When these issues arise, it's a reminder to all of the importance of putting your hospital legal counsel and risk manager on speed dial. ■

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How Much Protection Do 'Good Samaritan' Laws Really Offer EPs?

If a well-intentioned EP rushes to a person's aid, but harms that person, who then sues the EP for malpractice, is the EP protected by the "Good Samaritan" law? The answer depends on where the care took place, if the EP received compensation, and in what state the EP is located, among other factors, according to legal experts interviewed by *ED Legal Letter*.

"Without Good Samaritan statutes, many health professionals might

be hesitant to provide help for fear of being sued," says **William Sullivan**, DO, JD, FACEP, an emergency physician at the University of Illinois in Chicago and a practicing attorney in Frankfort, IL.

William M. McDonnell, MD, JD, clinical service chief of pediatric emergency medicine and medical director of the ED at Children's Hospital & Medical Center in Omaha, NE, says, "Good Samaritan laws are a fairly recent legal principle, established to overcome certain undesired effects of the previous legal structure."

Under the pre-existing common law rule of negligence, if a bystander volunteer provided help to the victim of an emergent injury or illness, and that help was not what a "reasonable person" would have done under the circumstances, then the victim could sue the volunteer for injuries that were caused by the "help."

This rule was intended to discourage unqualified bystanders from causing more injury.

"However, it also had the unfortunate effect of discouraging helpful volunteers from offering assistance," McDonnell notes.

In response, all 50 states enacted so-called "Good Samaritan" laws.

"These provide certain legal protections for good faith attempts to help, even if the assistance is technically 'negligent,'" McDonnell explains.

Richard Cahill, Esq., vice president and associate general counsel at The Doctors Company in Napa, CA, says that to minimize the potential for civil actions alleging professional negligence, EPs should understand:

- the circumstances in which the Good Samaritan immunity applies;
- the situations in which it is specifically excluded by statute;
- those events in which the immunity may be lost inadvertently.

EXECUTIVE SUMMARY

"Good Samaritan" statutes exist in all 50 states, but legal protections vary depending on multiple factors. EPs should be aware that the laws generally don't apply in these cases:

- If the EP received compensation;
- If the care was provided in the ED setting;
- If the care was grossly negligent.

"What a practitioner fails to appreciate may lead to otherwise avoidable litigation," Cahill warns.

States Vary Significantly

Although Good Samaritan statutes exist, Sullivan says, "the content and protections provided in those statutes can vary considerably." He gives these three examples:

- The Illinois Good Samaritan statute (745 ILCS 49/25) immunizes physicians who "in good faith, provide emergency care without fee to a person [except willful or wanton misconduct]."
- Florida's Good Samaritan statute (Florida Statute 768.13(2)) covers care that is rendered outside a hospital without objection of the injured victims when the provider "acts as an ordinary reasonably prudent person would have acted under the same or similar circumstances."

The Florida statute also covers all EMTALA-related care within the hospital, unless the treatment demonstrates "a reckless disregard for the consequences so as to affect the life or health of another."

- Georgia's Good Samaritan statute (OCGA 51-1-29) protects any person who "in good faith renders emergency care at the scene of an accident or emergency to the victim or victims thereof without making any charge therefor."

Georgia's statute also protects any emergency medical care that was provided unless "it is proven by clear and convincing evidence that the physician or healthcare provider's actions showed gross negligence."

"Just in these few examples, you can see that the statutory language differs significantly," Sullivan says, suggesting EPs perform a Google search on the Good Samaritan statutes in their own states to be familiar with what actions are and are not covered.

Defining Reasonable Care

Sullivan says that, generally speaking, "reasonable care" under the statutes would include basic first aid, basic life support, and Advanced Cardiovascular Life Support (ACLS) — if the EP was trained in ACLS.

"The further one strays outside of these guidelines, the more likely it is that Good Samaritan statutes might not apply," Sullivan cautions.

Here, Cahill reviews some important differences in state statutes:

- Some jurisdictions require that the physician render medical attention in accordance with what is reasonable or prudent under the circumstances consistent with the limitations specified within the statute.

"Other states provide immunity

unless the practitioner committed conduct variously expressed as gross negligence, willful acts, or misconduct," Cahill says.

• In some states, the scene of an emergency may include a healthcare institution, or as in Florida, where the statutory definition extends the protection to physicians' offices or other locations having "proper medical equipment."

• Many states, including California, Indiana, and Minnesota, specifically exclude Good Samaritan immunity for emergencies occurring in a healthcare facility such as a hospital ED, or even places where medical care usually is offered.

• Some states extend Good Samaritan immunity to individuals other than licensed physicians.

"For example, Arizona authorizes immunity for ambulance attendants, drivers, or pilots providing services at the scene of an emergency," Cahill notes.

In addition to physicians and surgeons, Connecticut provides statutory protection for dentists, registered nurses, and individuals certified as licensed practical nurses.

Other jurisdictions, including Michigan, grant immunity to certain allied health professionals, such as registered professional nurses, physician assistants, and licensed practical nurses, as well as licensed EMS providers.

• Some state statutes mandate that the practitioner act in good faith and without receiving any compensation.

"Depending upon the legislative language and intent, the immunity extended to physicians generally includes both acts of omission and commission," Cahill says.

The laws try to strike the right balance between reducing liability risk enough to motivate volunteers to act, while preserving enough liability risk to prevent harmful interventions, McDonnell says.

"Good Samaritan laws have definite limitations," he cautions. Here are some examples:

• The protections afforded by Good Samaritan statutes usually do not apply if care is deemed grossly negligent or constitutes "willful and wanton misconduct."

Even if the care is "negligent," the EP is protected. However, if the EP goes beyond "negligent" and acts with "gross negligence" or "willful and wanton misconduct," the protection disappears, McDonnell says.

THE LAWS TRY TO STRIKE THE RIGHT BALANCE BETWEEN REDUCING LIABILITY RISK ENOUGH TO MOTIVATE VOLUNTEERS TO ACT, WHILE PRESERVING ENOUGH LIABILITY RISK TO PREVENT HARMFUL INTERVENTIONS.

A recent Texas case illustrates the issue.[1] The court concluded that failing to recognize "telltale signs" of rhabdomyolysis on a urinalysis did not rise to the level of "gross negligence" where the doctors "knew about the peril of [the patient's] medical condition, or that … they proceeded with a conscious indifference to the [patient's] rights, safety, or welfare."

"Because the plaintiff could only prove ordinary negligence and not gross negligence, the court dismissed the malpractice suit," Sullivan says.

• The laws apply only to emergency situations.

Providing care to an unconscious patient or rescuing someone from a burning car would obviously be covered under the Good Samaritan umbrella.

"Giving offhand medical advice to someone at a dinner party likely would not," Sullivan says.

The Oklahoma Supreme Court stated that "keeping in mind that the Act's purpose is to invite medical providers to intervene, the term 'emergency' must be given the broadest sense possible."[2]

"Although this decision is only binding on Oklahoma cases, the sentiment behind this holding is similar in other cases when the definition of the term 'emergency' has been at issue," Sullivan explains.

Most courts use the "reasonably prudent person" rule to determine whether the circumstances were sufficiently "emergent" to justify Good Samaritan protections. "So the question will be: Would a reasonable person have thought that this was an 'emergency' situation?" McDonnell says.

• In general, the statutes are intended to apply only to care that is rendered outside of the hospital.

A 2002 New Jersey Court decision on whether Good Samaritan immunity should apply to in-hospital emergencies found that at the time, 11 state Good Samaritan statutes excluded emergency care provided in a hospital setting.[3]

"Seven statutes included emergency care provided within a hospital

setting. The other states had made no determination," Sullivan notes.

The court held that the act was created to encourage people to aid those who might otherwise lack care without the Good Samaritan immunity. "Since hospitals are where people typically go for care, the court held that the act should not apply to in-hospital emergencies," Sullivan says.

• The laws don't apply if there is an expectation of compensation.

"Unfortunately, there is no bright line rule about what constitutes 'compensation' sufficient to void the Good Samaritan protection," McDonnell says.

Clearly, if the volunteer physician sends the patient a bill, the care is not "voluntary." Thus, no Good Samaritan protection will apply.

"A token of gratitude from a shopping mall or airline after the physician assists one of their customers generally will not be considered compensation — but a large gift might," McDonnell warns.

In one case, a patient in a radiology suite went into cardiac arrest and was transferred to the ED, where "any available cardiologist" was paged over the intercom.[4]

A staff cardiologist responded, inserted a central line, performed a bedside echocardiogram, and made several attempts at a pericardiocentesis. Despite this, the patient died.

"The cardiologist argued that the Good Samaritan statute should apply because he had no pre-existing duty to the patient, and he did not bill for his medical care," Sullivan says.

However, the cardiologist also was unable to show any other time in his career that he had not submitted a bill for services provided to a patient.

The Illinois appellate court noted that refraining from charging a fee simply to invoke the protection of the Good Samaritan Act seemed to violate the statutory requirement that the doctor's actions be made in good faith.[3]

The court indicated this was particularly relevant, Sullivan notes, if the decision not to charge a fee was made following treatment that could potentially expose a doctor to liability.

McDonnell says, "Courts have ruled that even if there was no expectation of compensation at the time of care, if the doctor subsequently receives compensation, the protection disappears."

FOR TRUE VOLUNTEER EMERGENCY ASSISTANCE OUTSIDE THE MEDICAL WORKPLACE, GOOD SAMARITAN LAWS GENERALLY ARE EFFECTIVE IN SUPPORTING DISMISSAL OF ANY RESULTING NEGLIGENCE CLAIMS.

• The statutes probably will not apply if there is a pre-existing duty to provide care.

An EP probably would not be able to use the Good Samaritan defense for allegations of negligence regarding medical care provided to ED patients.

"The laws apply when the volunteer is not otherwise obliged to provide assistance, such as an existing physician-patient relationship," McDonnell explains.

The Good Samaritan defense might be more applicable to emergency care provided to a coding patient on the medical floor, provided that the EP typically does not bill patients for such care.

"Unless there is statutory language to the contrary, an expectation of compensation would likely negate this defense," Sullivan cautions.

For true volunteer emergency assistance outside the medical workplace, Good Samaritan laws generally are effective in supporting dismissal of any resulting negligence claims.

"However, location matters," McDonnell notes.

Good Samaritan laws generally do not apply to medical professionals while "on the job."

"This is because those professionals are not considered volunteers, but rather have an obligation to the victim," McDonnell says.

In some states, Good Samaritan laws extend protection to physicians in the hospital or medical workplace, but only to those who provide volunteer emergency services beyond the scope of their work duties.[5]

"However, in other states, Good Samaritan laws provide no protection to any physician providing volunteer assistance in healthcare settings," McDonnell says.[6]

This is a common misunderstanding held by EPs.

"Because this varies from state to state, it is important for physicians to investigate their own state laws," McDonnell urges. ■

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- **Richard F. Cahill**, Esq., Vice President & Associate General Counsel, The Doctors Company, Napa, CA. Phone: (800) 421-2368 ext. 4202. Fax: (707) 226-0370. Email: RCahill@thedoctors.com.
- **William M. McDonnell**, MD, JD, Clinical Service Chief, Pediatric Emergency Medicine/Medical Director, Emergency Department, Children's Hospital & Medical Center, Omaha, NE. Phone: (402) 955-5142. Email: wmcdonnell@ChildrensOmaha.org.
- **William Sullivan**, DO, JD, FACEP, Emergency Physician, University of Illinois, Chicago; Practicing Attorney, Frankfort, IL. Phone: (708) 323-1015. Email: wps013@gmail.com.

'Brief, Superficial' ED Interactions Spur Litigation

For a medical malpractice claim to exist, an adverse outcome must have occurred, and there must be an unsatisfied patient or family.

Sean P. Byrne, JD, a medical malpractice defense attorney in the Glen Allen, VA, office of Hancock, Daniel, Johnson & Nagle, helps healthcare providers, including EPs, prevent future litigation with proactive risk management.

"In my experience defending medical negligence cases, the patient's view of their relationship with the providers in the ED can significantly impact how they process an adverse outcome and whether they elect to pursue litigation," Byrne says. Here are some factors he has seen in ED malpractice litigation:

• The patient returned to the ED with a new or worsened condition that was not appreciated or recognized on initial presentation.

"Thus, the question is often whether it was a 'reasonable miss,'" Byrne says.

If patients think ED providers were rushed, inattentive, or disregarded their symptoms and complaints, they're much more likely to second guess the care and explore legal remedies.

• Patients didn't fully understand what occurred during the ED visit.

"Patient dissatisfaction after ED visits seems to be driven, at times, by not fully understanding their diagnosis and treatment plan," Byrne notes.

IF PATIENTS THINK ED PROVIDERS WERE RUSHED, INATTENTIVE, OR DISREGARDED THEIR SYMPTOMS AND COMPLAINTS, THEY'RE MUCH MORE LIKELY TO SECOND GUESS THE CARE AND EXPLORE LEGAL REMEDIES.

It often becomes apparent during litigation that patients can't identify various members of the ED team and didn't understand the respective roles team members played.

"Patients value introductions, explanations about the reason for tests, and updates during each phase of their care," Byrne says. This requires a combined effort by EPs, mid-level providers, ED nurses, and ED technicians.

• Patients didn't realize there was some degree of uncertainty associated with their diagnosis, and that there were critical things to watch for and respond to if their condition changed.

"Very commonly, the patient reports very little, if any, recollection of what they were told at discharge," Byrne says.

Byrne has found that detailed notes in the ED chart, along with written discharge instructions printed and given to the patient, often proves to be helpful evidence in the EP's defense.

• The patient or family says something to the effect of, "If only the EP had listened to what we were telling him/her."

One ED case alleged that the EP failed to appreciate and respond appropriately to an ileus/bowel obstruction. Prior to receiving a nasogastric tube, the patient vomited, presumably aspirated, coded, and died.

"During the litigation, the family expressed that the providers were not

attentive to their comments about the patient's distended abdomen, and ignored their concerns," Byrne says.

Risk-reduction Strategies

Byrne commonly hears from patients and family during depositions in ED cases that they perceived their interaction with the EP or mid-level provider as "brief and superficial."

"At times, they will allege that the provider was inattentive, dismissive, or even rude," he adds.

Since EPs don't have long-term relationships with patients, says Byrne, "that makes it even more important that the communication that does happen in the ED is thoughtful, comprehensive, and compassionate." He suggests that EPs utilize these risk-reducing practices:

- Practicing "the basics" of good communication. This includes making eye contact, acknowledging each person in the room, apologizing for delays, and demonstrating a willingness to listen.
- Learning how to communicate with dissatisfied patients and address their concerns constructively. "This is a skill that requires education, training, and experience, just like clinical skills," Byrne says.

Byrne has seen multiple cases in which ED patients expressed dissatisfaction with the care they received and asked to speak with the EP. EPs typically are reluctant to engage in these conversations.

"This is because of the discomfort associated with it," Byrne says. "There is also a fear of litigation, of what you say being used against you in a court of law."

- Using an "ask-tell-ask" approach. "This ensures effective 'closed-loop' communication," Byrne says. The EP asks patients open-ended questions and assesses their existing knowledge before sharing information.

"When patients feel as though they were heard and understood, they have more ownership over the healthcare delivery process," Byrne says. "They are less inclined to place blame when the outcome is undesired." ■

SOURCE

- **Sean P. Byrne**, JD, Hancock, Daniel, Johnson & Nagle, Glen Allen, VA. Phone: (804) 237-7409. Email: sbyrne@hdjn.com.

Study: EMTALA Violations Found 40% of Time

But only 3% triggered fines

Violations of the Emergency Medical Treatment and Labor Act (EMTALA) were found in 40% of investigations conducted by CMS.

However, only 3% of investigations triggered fines, according to a recent study of 2,436 complaint cases surveyed by CMS in conjunction with state agencies.[1]

This surprised **Larry D. Weiss**, MD, JD, FAAEM, MAAEM, one of the study's authors. Weiss is clinical professor of emergency medicine at University of Maryland School of Medicine in Baltimore.

"CMS never explained why only a small percentage of supposed infractions result in fines, so I can only speculate," Weiss says.

State departments of health almost always perform the initial investigations. The teams of inspectors almost never include attorneys.

"It is very difficult for non-attorneys to understand the complexities of EMTALA, all the regulations, and all the relevant case law," Weiss says. "I believe inspectors often apply EMTALA inappropriately."

It's possible that CMS realizes that many of the supposed infractions do not merit a fine. "Also, some of the supposed infractions are minimal and do not involve any wrongful conduct or intent to violate the law," Weiss adds.

However, the low incidence of fines might be misleading. "In every case, the possibility exists that an investigating team may want to review many cases by the same physician or many

EXECUTIVE SUMMARY

Although violations were found in 40% of EMTALA investigations, only 3% triggered fines. However, investigators might find other problems with compliance if the ED is surveyed. To reduce risks:

- Periodically audit charts to make sure staff document compliance.
- Post required EMTALA signs exactly as regulations require.
- Don't send patients brought by ambulance to another facility with only a cursory examination.
- Take hospital policies seriously, with no shortcuts.

transfers from the same hospital," Weiss stresses. Investigators can levy a separate fine for each infraction they find.

The study looked only at CMS-imposed fines. Researchers did not examine litigated cases filed by patients against hospitals — another source of possible liability. "Patients may sue hospitals for damages sustained from alleged violations of EMTALA," Weiss notes.

Most Involve Screening

Weiss says, "No paper in the emergency medicine literature ever studied the incidence of EMTALA complaints, the distribution of the various complaints, and the aggregate outcome of these complaints and investigations."

By far, failure to provide an appropriate medical screening examination (MSE) was the most common complaint. Of 192 settlements:

- 75% were for failing to provide screening;
- 42% were for failing to stabilize patients with emergency medical conditions;
- 15% were due to the patient's insurance or financial status.

Timothy C. Gutwald, JD, a healthcare attorney in the Grand Rapids, MI, office of Miller Johnson, was surprised that so many EDs are still getting tripped up on MSEs.

"At this point, EDs should recognize the difference between triage and an MSE, and know what qualifies as an MSE," he says.

However, a May 2016 survey of Sioux San Hospital in Rapid City, SD, demonstrated this isn't always true. CMS found the hospital failed to provide timely and sufficient MSEs for nine of 32 ED patients.

"Over the years, violations have shifted from dumping patients for financial reasons to more technical compliance issues — like conducting a timely and proper [MSE]," Gutwald says.

Prevent Investigations

In Gutwald's experience, scenarios involving complaints of severe pain and patients presenting with mental health issues are particularly tricky for EDs. It can be difficult for ED providers to distinguish between legitimate complaints of pain and drug-seeking behavior.

NEW HIRES FAIL TO UNDERSTAND THE NUANCES OF DEFINITIONS AND ENFORCEMENT PATTERNS OF EMTALA AT THE ED'S PERIL.

"It is also challenging to know when a patient who presents with mental health issues has been stabilized for purposes of EMTALA," Gutwald adds.

He suggests periodically auditing ED charts to check for proper documentation of EMTALA compliance.

"A combination of high patient volumes and staff turnover, coupled with ineffective, infrequent training, continue to trip up EDs," Gutwald says.

Not surprisingly, ED documentation is extremely helpful in the event someone files a complaint.

"A frivolous complaint will not get far if the medical record demonstrates a proper MSE was performed and that the patient was stable prior to discharge," Gutwald says.

Stephen A. Frew, JD, vice president of risk consulting at Johnson Insurance Services and a Rockford, IL-based attorney, says EMTALA violations occur at about the same level today as in the 1990s. At that time, HMOs were trying to keep insured members out of the ED to reduce costs. In some ways, the same thing is happening today.

"The unabated frequency of citations can be partially attributed to financial pressures from managed care and other third-party payers to keep patients out of EDs," says Frew, who describes EMTALA education as "still dismally low."

Even hospitals that make staff training a top priority face many competing priorities, such as compliance with The Joint Commission's standards. EMTALA sometimes is overlooked.

Frew used to find it counterintuitive to see repeated violations happening even at hospitals that were serious about EMTALA training.

"But the longer I have been in the business, the more apparent it is that a major factor is staff turnover," he says.

New hires fail to understand the nuances of definitions and enforcement patterns of EMTALA at the ED's peril.

"They respond to situations from a 'common sense' approach," Frew says. "This does not conform to the highly structured EMTALA regulatory approach."

Here are two problems that Frew sees in many EDs:

1. The failure to post EMTALA signage in each and every area as required by the regulations.

"This is the single most common — and most simple — citation I see," Frew says. Some examples include:

• Hospitals repaint and don't rehang signs;

• Hospitals put signs up in the ED, but not in other areas such as obstetrics;

• Signs aren't large enough to be read clearly from 20 feet away;

• Signs are not clearly visible from all angles in the waiting area;

• Hospitals post only one sign, when they are supposed to post signs at every treatment room, waiting area, entrance, and registration area;

• Hospitals don't post signs in the ambulance entry area;

• Other signs are viewed by CMS as conflicting with the EMTALA signs. These include copay notices, notices for self-pay requirements, current wait times, and pain medication policies. "These signs are viewed as 'coercive' in suggesting patients go elsewhere," Frew explains.

• "Glance and go" transfers.

After receiving a report from an inbound ambulance, the EP believes the patient is in serious condition and needs to go to another ED.

"He or she runs out to the ambulance, takes a quick look at the patient, and orders the ambulance to go to a more distant hospital," Frew says.

This patient has legally "presented" to the ED, according to EMTALA. But there has been no MSE (as it's legally defined), no stabilizing care, no advanced acceptance from the next hospital, no transfer forms, no documentation, and no medical records transfer.

"In short, good intentions do not equal legal compliance," Frew says.

2. Failure to follow hospital policies.

Frew estimates that in two-thirds of citations, the hospital has an applicable policy that was shortcut or outright ignored.

"EMTALA is a 'zero tolerance' regulation, as enforced by CMS," he adds.

EMTALA explicitly requires policies and procedures, training on those policies and procedures, and an internal quality and process improvement approach to monitor and correct mistakes. Frew notices a growing trend of ED staff failing to take this seriously.

> "SOMEWHERE ALONG THE LINE, THESE FOLKS HAVE GOTTEN THE IDEA THAT POLICIES AND PROCEDURES ARE 'HELPFUL SUGGESTIONS.'"

"Somewhere along the line, these folks have gotten the idea that policies and procedures are 'helpful suggestions,'" Frew says.

Many times, citations can be traced back to somebody with this lax attitude.

"They do not seem to understand or care that policies and procedures are the criteria that they will be held to in compliance enforcement and malpractice lawsuits," Frew says. ■

REFERENCE

1. Zuabi N, Weiss LD, Langdorf MI. Emergency Medical Treatment and Labor Act (EMTALA) 2002-15: Review of Office of Inspector General patient dumping settlements. *West J Emerg Med* 2016;17:245-251.

SOURCES

- **Stephen A. Frew**, JD, Vice President, Risk Consulting, Johnson Insurance Services, Loves Park, IL. Phone: (608) 658-5035. Fax: (815) 654-2162. Email: sfrew@medlaw.com.
- **Timothy C. Gutwald**, JD, Healthcare Attorney, Miller Johnson, Grand Rapids, MI. Phone: (616) 831-1727. Fax: (616) 988-1727. Email: gutwaldt@millerjohnson.com.
- **Larry D. Weiss**, MD, JD, FAAEM, MAAEM, Clinical Professor of Emergency Medicine, University of Maryland School of Medicine, Baltimore. Phone: (410) 328-8025. Fax: (410) 328-8028. Email: lweiss@em.umaryland.edu.

CME/CE OBJECTIVES

After completing this activity, participants will be able to:

1. Identify legal issues related to emergency medicine practice;
2. Explain how the legal issues related to emergency medicine practice affect nurses, physicians, legal counsel, management, and patients; and
3. Integrate practical solutions to reduce risk into daily practice.

COMING IN FUTURE MONTHS

- Identify EPs at higher-than-average risk for malpractice suits
- Practically foolproof defenses if ED patient leaves against medical advice
- Little-known legal pitfalls if ED transfers a psychiatric patient
- How EP reacts to "frivolous" lawsuit can complicate the defense

ED LEGAL LETTER

CME/CE INSTRUCTIONS

To earn credit for this activity, please follow these instructions:

1. Read and study the activity, using the provided references for further research.
2. Log on to **AHCMedia.com** and click on My Account. First-time users will have to register on the site using the eight-digit subscriber number printed on their mailing label, invoice, or renewal notice.
3. Pass the online tests with a score of 100%; you will be allowed to answer the questions as many times as needed to achieve a score of 100%.
4. After successfully completing the test, a credit letter will be emailed to you instantly.
5. Twice yearly after the test, your browser will be directed to an activity evaluation form, which must be completed to receive your credit letter.

CME/CE QUESTIONS

1. **Which is true regarding legal protections extended to EPs under "Good Samaritan" laws?**
   a. State statutes contain only minor differences in language from state to state, and the statutes generally don't vary in immunity provisions extended to physicians.
   b. All statutes specifically cover care rendered in a healthcare facility, such as a hospital ED.
   c. Negligent care (i.e., "ordinary negligence") is not protected.
   d. Most courts use the "reasonably prudent person" rule to determine whether the circumstances were sufficiently "emergent" to justify Good Samaritan protections.
2. **Which is true regarding legal protections and compensation under "Good Samaritan" laws?**
   a. The protections apply even if the patient compensates the volunteer physician, unless the patient is billed for the care by the physician or hospital.
   b. There is no bright line rule about what constitutes "compensation" sufficient to void the Good Samaritan protection.
   c. Court rulings make it clear that the protection is still in place even if the physician ultimately receives some type of compensation, as long as there was no expectation of compensation at the time of care.
   d. Large gifts made as a token of gratitude cannot be considered as compensation under the law because the physician did not charge a fee for his or her services.
3. **Which practice does Sean P. Byrne, JD, believe is legally protective for EPs?**
   a. Omit introductions of various ED team members caring for the patient so as to avoid an overload of information.
   b. Inform patients if there is some degree of uncertainty associated with the diagnosis.
   c. Refer dissatisfied patients to hospital administration instead of addressing the concern directly.
   d. Rely mainly on verbal communication at discharge.
4. **Which is true regarding EMTALA compliance?**
   a. One reason for continued violations is high turnover, with new hires failing to fully understand requirements.
   b. While hospitals are required to post some type of sign in the ED, posting additional signage in ambulance entry and registration areas is left to the discretion of the hospital.
   c. CMS has clarified that signs about copays and self-pay requirements are not in conflict with EMTALA.
   d. Patients arriving by ambulance have not legally "presented" to the ED as defined by EMTALA, if the EP orders the ambulance to go to a more appropriate ED.