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INSIDE

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Court Applies EMTALA to Hospital's Urgent/Walk-in Care Center

By Robert A. Bitterman, MD, JD, FACEP, President, Bitterman Health Law Consulting Group, Inc., Harbor Springs, MI

A Rhode Island federal court determined that under the Centers for Medicare and Medicaid Services (CMS) Emergency Medical Treatment and Labor Act (EMTALA) regulations, a walk-in urgent care center was a "dedicated emergency department" (DED) because it held itself out "as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment."

Patricia Friedrich presented to the South County Hospital Medical & Wellness Center's urgent/walk-in care facility complaining of severe pain and burning in her chest and right arm. Prior to arrival, she had sent several text messages to coworkers indicating that she needed to be checked out at the emergency room, and that she had seen the "South County Walk-In Hospital" from the highway, so she pulled in to get evaluated. She also texted that she felt she had all the symptoms of a female heart attack, but "knew it couldn't be" … "but since I'm not a doctor I thought it was a good idea to get checked out."[1]

The on-duty physician examined her, obtained several tests, and diagnosed her symptoms to be due to gastroesophageal reflux disease. She was treated with a "GI cocktail" and discharged with no follow-up ordered. The next day, Friedrich was found unresponsive at home and could not be revived by EMS personnel. An autopsy confirmed cardiovascular disease as the cause of death.[1]

The patient's family sued the hospital and urgent walk-in center in federal court under EMTALA, claiming that medical personnel

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failed to appropriately medically screen and stabilize the patient's emergency medical condition.[1] The hospital filed a motion for summary judgment to get the case dismissed, claiming that EMTALA did not apply to its urgent walk-in center.[1]

To answer the question of whether EMTALA applied to this center, the court had to decide whether the hospital's urgent/walk-in facility was a DED under EMTALA.[1]

The Court's Opinion

First, the court noted that the center had to be a department of South County Hospital for there to be any possibility of attaching EMTALA duties. EMTALA only applies to Medicare-participating hospitals,[2] but that includes any on-campus or off-campus hospital departments.[3] South County Hospital was a Medicare-participating hospital, and it conceded that this center was operated as an off-campus "department of the provider" under its Medicare provider agreement.[1]

Next, the court noted that under EMTALA an individual must come to a hospital's DED and request examination or treatment for a medical condition to trigger the medical screening exam (MSE) and stabilization duties of the law.[4] The "request" prong also was conceded, but the hospital contended its urgent walk-in care center was not a DED.

CMS has defined a DED as "any department or facility of the hospital, regardless of whether it is located on or off the main hospital campus" that meets at least one of three requirements:

- It is licensed by the state in which it is located under applicable state law as an emergency room or ED;
- It is presented to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or
- During the calendar year immediately preceding the calendar year in which a determination under this section is made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment.[3]

The court determined that this urgent/walk-in care center qualified as a DED under the second requirement: The center held itself "as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment."[1]

The hospital had deliberately used the word "urgent" in naming its facility, when it could have simply called it a "Walk-In Clinic." Evidence in the case showed that Friedrich, based on the name of the clinic, thought she was going to a hospital emergency room, as she had texted several coworkers that she had "gone to the ER."

The hospital argued that its urgent/walk-in facility's website made clear that it did not offer emergency care; however, the court noted that someone driving by the center with an emergency medical need "certainly could not be expected to check the website before walking in with chest pain."[1] The court noted that CMS perceives no distinction between "urgent" and "emergency" care, stating in its 2003 EMTALA Final Rule that established the definition of a DED: "We believe it would be

very difficult for any individual in need of emergency care to distinguish between a hospital department that provides care for an 'urgent need' and one that provides care for an 'emergency medical condition' need. Indeed, to CMS, both terms seem to demonstrate a similar, if not exact, functionality."[5]

Additionally, CMS had proclaimed that "the definition of [DED] would also be interpreted to encompass those off-campus hospital departments that would be perceived by an individual as appropriate places to go for emergency care."[5]

Because the court found that the hospital had presented its urgent/walk-in facility "as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment," it denied the hospital's motion to dismiss the case.[1]

Comments

First, it's important to understand that because the ruling made was a motion for summary judgment by the hospital, the court didn't actually decide whether the urgent/walk-in center was a DED. Instead, the court determined that as a matter of law, the hospital wasn't entitled to have the case tossed out of court before trial. At trial, the plaintiffs still must prove that the urgent/walk-in care center presented itself in such a way as to be considered a DED. It will be up to the jury to decide whether the facility presented itself as such. If so, the jury must decide whether the hospital violated EMTALA.

Since this care center was a provider-based hospital department, meaning it was owned by the hospital and operated under the hospital's Medicare provider number, it probably was billing under the Emergency Department E&M codes, rather than under office-based codes, a fact the court did not address but one a good plaintiff's attorney will raise at trial since it makes the center look even more like an ED.

If this center had not been operated under the hospital's Medicare number, it would have carried no possible liability under EMTALA.[6] The law only applies to Medicare-participating hospitals.[7] Accordingly, urgent/walk-in care centers owned and operated by physicians do not have to comply with EMTALA. However, hospitals can own and operate such centers without EMTALA liability, provided the facilities are legally structured to avoid the attachment with the hospital's Medicare provider number.[8]

Even if an urgent/walk-in care center provided emergency services and advertised and held itself as an actual ED, it would carry no liability under EMTALA if it was not operated as a department of a Medicare-participating hospital.[9] That's why EMTALA doesn't apply to physician-owned, free-standing EDs, although many states, such as Texas, have enacted "EMTALA-like" laws applicable to non-hospital, free-standing EDs.[10]

CMS believes that hospital-owned urgent care centers (UCCs) almost always are DEDs, because such centers are held out as appropriate for urgent conditions; to the public, the words "urgent" and "emergency" are virtually synonymous. In fact, when CMS promulgated the EMTALA rules for off-campus hospital departments, the agency expressly rejected exempting UCCs from the DED definition, stating that they expected these entities "would in practice be functioning as 'off-campus emergency departments.'"[11] From the beginning, CMS intended EMTALA to apply to UCCs, and the courts are helping that along. UCCs may be the newest addition to the list of other hospital departments (besides the traditional ED) that present themselves to the public as providing care for patients presenting with emergency medical conditions and, thus, qualify as DEDs, along with labor and delivery units, pediatric EDs, psychiatric EDs, and typical psychiatric intake centers.

The manner in which UCCs, walk-in clinics, or variants thereof are legally structured, named, advertised, staffed, billed out, become known in the community, draft policies and procedures, operate under state licensing laws, are discussed, relate to EMS and other hospitals, etc., all become relevant to determining when a particular UCC will be considered a DED. It becomes a facts-and-circumstances determination, which the hospital/UCC must consider and control in advance and/or prove/defend at trial.

However, the key issue in this Rhode Island case is that many hospitals still don't understand EMTALA's definitions or the CMS implementing regulations. The definitions really matter and can mean something entirely different from what is usually understood by healthcare providers. It's relatively easy to establish UCCs that don't carry EMTALA obligations, provided the hospital engages counsel/experts in EMTALA who know how to legally structure and operate the UCC.[12] Many large healthcare systems across the country have executed it successfully. Any hospital considering acquiring or starting an urgent/walk-in-type facility should first determine whether they can

live with EMTALA's mandates, or whether they want to structure the entity to avoid EMTALA's reach. ■

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Case Law Expanding ED's Legal Exposure if Discharged Psychiatric Patient Commits Violence

Exposure 'most acute for ED providers'

Healthcare providers' liability exposure for potentially violent ED patients could be expanding nationally. "ED providers are right at the forefront of that," says **Eric J. Neiman**, JD, managing partner in the Portland, OR, office of Lewis Brisbois.

A December 2016 Washington Supreme Court decision involved an outpatient psychiatrist, "but it could easily extend to the ED setting," Neiman notes.[1]

The court ruled that a psychiatrist could be held liable for homicides committed by a patient, even though the patient never identified the victims as targets of violence. The decision potentially expands liability not just for mental health professionals but also other healthcare providers. "The exposure created by that case is most acute for ED providers," Neiman warns.

Neiman does not see this case as an outlier. "Many states are expanding different types of tort liability, using the concept of foreseeability as the standard. Foreseeability is almost always a jury question."

The case was never tried because a settlement was reached out of court. Thus, there is still an unanswered question, Neiman reports. "Are we going to hold an EP responsible for the inability to predict violent behavior, which most people agree is inherently unpredictable?"

Statutory Protection Possible

A recent New York appellate court ruling affirmed the dismissal of a medical malpractice action against an EP who, based on the triage nurse's feedback, as well as drug screening and mental health evaluation of the patient, discharged a patient who subsequently committed suicide.[2]

The ruling affirmed the lower court's dismissal based on the ED record. The ED chart contained a mental health evaluation of the patient and other medical records supporting the discharge. This included the extensive mental health evaluation of the patient by a registered nurse from the defendant hospital's behavioral health unit.

"Recent case law continues to emphasize the need for prophylactic measures, such as psychiatric evaluations, when concerns are raised about a patient's mental state," says **Paul D. Squire**, JD, lead partner of the healthcare practice at New York City-based Kaufman Borgeest & Ryan.

William M. Mandell, JD, chair of the health law practice at Boston-based Pierce & Mandell, says, "The management of patients coming to an ER who possibly have psychiatric issues that border on questions of safety and endangerment to self or others is obviously very much on everyone's mind these days."

Whether discharge or involuntary commitment is appropriate is a decision the ED clinician should make in concert with the clinical and administrative team and, if necessary, the input of hospital legal counsel,

Mandell offers. Patients' rights laws, duty to warn laws, and privacy laws all must be taken into account, as well as involuntary commitment statutes. These often offer good faith immunity if the ED clinician reasonably believes there is danger of imminent harm if the patient is discharged.

If protective measures are not taken for a patient that could present imminent harm, and the patient is released from the ED and harms himself or herself or third parties, "there would be potential liability for the ER doctor," Mandell stresses.

Another thorny legal dilemma for emergency physicians (EPs): how to handle a troubled patient who may not be deemed to present imminent harm, but is learned to have possession of a dangerous weapon. "What's become apparent is that not every perpetrator of violent acts who was seen by an ED presented as a mental health patient who is in imminent need of involuntary commitment," Mandell explains. Some states have instituted "red flag" laws that, short of an involuntary commitment action, allow for guns to be taken away from a troubled person through court intervention.

While the EP has a clear duty to warn if a patient states that he intends to kill a specific individual, some patients make more general threats.

"What if the patient says, 'Sometimes, I feel so mad I just want to go out and kill everyone I see.' Is that enough to take action?" Mandell asks. "I would submit, in this day and age, it should be."

If the patient did commit violence after making a statement like that, there would be clear liability for the EP who didn't act on the warning, Mandell adds.

Another important consideration is that good faith immunity laws protect EPs who initiate involuntary commitment and are sued later for civil rights violations.

"All you can do is make a reasonable effort to gather all the facts, and make your best judgment about the proper course of action," Mandell says.

Most states have included immunity provisions in civil commitment laws for decisions that are made pursuant to those laws, Neiman notes. This means there can be statutory protection for detaining an ED patient — or for not detaining an ED patient. It's not ironclad. Specific documentation is required. "The ED provider needs to document his or her thought process," Neiman says. The documentation does not need to be elaborate. It could be as simple as stating, "Considered detention pursuant to civil commitment laws and determined patient did not meet criteria."

"Document that the civil commitment option has been considered, and briefly explain why it was or wasn't used, and it might bring you into the immunity statute," Neiman explains.

EMTALA Is Basis to Hold

The 2016 Washington Supreme Court ruling underscores the legal risks of discharging home a possibly violent ED patient. But holding these patients also carries legal risks for EDs. Recently, courts have challenged the legality of boarding psychiatric patients in the ED. In 2014, the Washington Supreme Court ruled the practice unlawful.[3]

When the EP requests a patient be held, court investigators often determine that civil commitment criteria for detention have not been met. That doesn't mean the EP's obligation is over and the patient can be discharged without any legal risk.

"That's not the end of the discussion, because you still have an EMTALA [Emergency Medical Treatment and Labor Act] obligation," Neiman cautions. "Actually, that can be very helpful. That's when EMTALA is your friend."

EMTALA can provide a basis to hold the patient in this scenario. This is because the patient has an emergency medical condition — in this case, a psychiatric disorder that makes the patient a danger to self or others.

"In cases where it just doesn't feel right to let somebody leave because of what they're verbalizing, and the court investigator says don't hold the patient, EMTALA can be the basis to hold," Neiman explains.

A persistent misconception is that EMTALA doesn't apply to psychiatric patients. "There are still people who believe that, and it's just wrong," Neiman says. "In 2017, almost half of the cases that the OIG [Office of Inspector General] settled based on EMTALA violations involved psychiatric patients."

The OIG has been clear: Boarding of psychiatric patients in EDs is a top enforcement priority. "The volume of psychiatric patients coming through is greater than it used to be, not necessarily because of the percentage of diagnoses, but because of length of stay," Neiman adds.

Long Waits to Assess

With some states expanding civil commitment laws to include overdoses, there will be more situations in which ED providers have to consider the use of civil commitment laws. "That's something that I don't think has gotten enough discussion yet," Neiman says.

In some locations, it can take days to get a court investigator to come to

the ED to assess a patient. "My sense is that there is wildly different access to the court commitment system around the country, just like there's wildly different access to mental health professionals," Neiman offers. For instance, in Washington state, the initial assessment has to take place within six hours; in Oregon, patients can be detained only for five days before a hearing must take place. Other states allow patients to be boarded until they can be brought to court.

Some EDs conduct the mental health assessment in conjunction with the court commitment system. "The crisis team in the community, which has the authority to detain, does the assessment in some places. That fills a gap with resources in the hospital," Neiman says. Good documentation on why the EP believes the patient is safe to discharge is important, Neiman adds. At a minimum, it should state, "No SI [suicidal ideation] or HI [homicidal ideation]."

"I have seen some records where that is not included in the physician's assessment, and that's a problem," Neiman warns. Additional specific information, such as the patient's lack of access to firearms, or having a good support network, is better.

Building a good working relationship with court investigators, or whoever coordinates placements in the community, can help in difficult situations. "When you have discussions about better patient flow, in the context of frustration over a particular patient, that's not necessarily a productive conversation," Neiman says. Emotions are running high at that point because there's concern about what might happen with that particular patient if [he or she is] discharged, and the impact on the ED at the moment.

A better approach: Start a more general dialogue about how the ED, the hospital, the court investigator, and mental health agencies where patients are referred can all serve the patient population better.

"Having a discussion about the relationship between the hospital and the commitment system takes time," Neiman says. "But it really pays off." ■

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Lack of Discussion With Supervising EP Key Focus of PA Lawsuits

Absence of documentation implicates supervising EPs

Physician assistants (PAs) are providing much-needed staffing in EDs and are assuming more independence. EMRs provide anyone reviewing the chart with the names of every clinician involved in an ED patient's care. "For these reasons, PAs are being named more frequently in lawsuits," says **Susan Martin**, Esq., executive vice president of litigation management and loss control at AMS Management Group, a Fort Lauderdale, FL-based medical professional liability insurer. Previously, Martin managed litigation and risk management for EmCare and and worked as an ED nurse manager.

"PAs more than likely provide added protection for the physician during volume surges in EDs," Martin adds. Of 3,277 malpractice claims that occurred in the ED that closed between 2012 and 2016 in CRICO Strategies' National Comparative Benchmarking System database, only 61 named PAs. "The reality is the legal risks for PAs are no different than for emergency physicians. And research shows that PAs incur a remarkably low rate of malpractice claims paid against them," says **Berit Mansour**, director of media relations for the American Academy of PAs.

However, when malpractice allegations arise against PAs, the supervising EP is likely to be named in the lawsuit. Communication between the two providers, or lack thereof, usually is a precipitating factor.

A recent case involved a 45-year-old man who presented to an ED with epigastric and chest pain. He

received a GI cocktail, and underwent an ECG and cardiac enzymes study. A PA saw the patient, who improved after a period of observation. "The PA never discussed the patient, or disposition, with the ED physician," Martin recalls.

The patient died of sudden cardiac arrest the next day. The family sued the PA, the supervising EP, and the hospital. The case was settled against the PA and ED group. These were key areas of focus during the litigation:

- whether it's acceptable for patients with acute chest or abdominal pain to be seen only by a PA;
- that the ED did not have written protocols for high-risk patients, which require discussion and disposition by the EP;
- whether the bad outcome was due to an individual practitioner who could have approached the EP with concerns, or whether it was due to the ED's lack of protocols.

After the event, the hospital and ED group put in protocols that chest pain, abdominal pain, and other high-risk complaints must be reviewed by the supervising EP. "Any such protocol should allow the PA to request discussion on any patient in which he or she has concerns," Martin adds. If the physician signs off on the chart, they are "assumed" to agree with the care, Martin notes. The PA should document that the case was discussed with the EP, and whether the EP agrees with the plan. Any allegations of negligence against a PA require a "reasonable and prudent physician assistant" standard, as opposed to the standard of care an EP would be expected to meet. "However, the PA will need to show that he or she is licensed, trained, and experienced in emergency medicine," Martin offers.

Julye Johns, JD, an attorney with Atlanta-based Huff, Powell & Bailey, represented a PA who discharged a patient after discussing the case with a physician. The patient developed diabetic ketoacidosis and eventually died. In her deposition, the PA testified she spoke with the physician. "The physician did not recall the discussion, and there was no note of the discussion in the record," Johns recalls. "Both the PA and the physician were sued as a result." The trial ended with a defense verdict.

"But this is a warning that an emergency physician who has agreed to supervise a PA may be sued, even when she never saw the patient, never reviewed the record, and does not remember the patient," Johns says.

Johns says good documentation is:

- **Legally protective for the PA.** "Spoke with Dr. X. She agreed with plan of discharge, follow-up with primary care provider in 48 hours, and recommendation to return to ED if no improvement. Patient expressed understanding and agreement with plan."
- **Legally protective for the EP.** "Consulted by PA X regarding patient. Reviewed the chart and agreed with disposition based on presenting complaints, improvement in condition, test results, and patient's understanding of discharge instructions to follow-up with primary care provider in 48 hours and recommendation to return to ED if no improvement."

"In general, a PA should document any communications with a supervising physician regarding a patient's care, treatment, and discharge, to the extent applicable," Johns offers. Informal consults often go undocumented. PAs tend to document conversations more often if there is a transfer of care, such as at shift change or due to a change in patient's acuity. "An emergency physician with whom the communication occurred will, in all likelihood, not make any such documentation," Johns adds. When a malpractice claim is filed years later, the PA's thorough documentation of a discussion with the supervising EP is an effective defense — for the PA, that is. It could work against the EP, Johns warns. "This same documentation can implicate a physician who never saw a patient, and who probably will not recall the communication." ■

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Tissue Plasminogen Activator Decision Remains Legal Landmine for EDs

A CT scan revealed stroke in a 60-year-old man found unresponsive in his truck.

"Because his downtime was unknown, we did not give tPA, and ended up getting sued," says **Rhamin Ligon**, MD, director of quality and risk management at Maryland Emergency Medicine Network in Baltimore.

The plaintiff attorney challenged the ED's assumption about the time frame being outside the treatment window for tPA. When the EP was asked if the patient's wife or employer was called, the answer was no. According to the plaintiff attorney, there was a timeline that perhaps could have been verified putting the patient inside the treatment window for the drug. The ED disagreed, based on the fact that the man's symptoms started in the morning, and he was found hours later.

Nonetheless, the fact that no one attempted to verify the timeline made the case more difficult to defend. "The lesson for us is: do due diligence, and try to verify the timeline if you can," Ligon offers.

Most lawsuits involving tPA allege the EP failed to give the drug, or that the drug wasn't given quickly enough.[1]

"A big issue we have with strokes is the public perception that tPA cures strokes. The expectation is that people are going to receive the drug and be cured," says **Mark Spiro**, MD, chief medical officer of the Walnut Creek, CA-based The Mutual Risk Retention Group.

In reality, a minority of stroke patients receive tPA. Almost all are outside the treatment window or don't meet the criteria for another reason. "About 80% of our stroke cases are for failure to give tPA, rather than for giving it inappropriately," Spiro says.

EPs also get sued for giving the drug, too. One such claim involved a woman who was very clear that she understood the risks and wanted to take a chance on tPA. "She went on to bleed and sued us, with a six-figure settlement," Ligon reports. The time frame became a key issue in this particular case. The patient was expected to barely meet the 4.5-hour time frame, which poses somewhat higher risks for intracerebral hemorrhage than the three-hour timeframe. The orders were written in a timely manner, but by the time the drug was actually given, it was 15 minutes outside the time frame. The plaintiff alleged that this contributed to the patient's bad outcome.

Ligon says the lesson for EPs is: "Be cognizant that you may write the order at a certain time, but that's not the time the drug is hung." Another issue was that the written consent could not be located. The ED chart continued good documentation of the verbal discussion with the patient, and the plaintiff didn't link the lost consent to causation. Still, the ED is considering some process changes. "We've talked about doing an electronic consent, or having another party document in the chart that the consent was obtained," Ligon says.

Inadequate discussions can trigger malpractice litigation involving tPA and stroke. It's not enough to simply tell patients or family members that they don't meet the criteria.

"You need to help them understand why. I don't know that we always do a good job of that," says Ligon, who chairs a risk management forum for his health system's 17 EDs. The group often discusses tPA-related litigation. "Everybody had at least one case where they did give tPA and it was tough to decide to give it, or a case where they didn't give it and it was a tough decision not to give it," she recalls.

Visual aids can help convey the realities of the drug to patients and families. Ligon says this is the best way to show that the vast majority of patients don't exhibit any improvement at all, some are worse off, and some people die after taking the drug. "In my experience, most patients actually decline the drug after learning that," Ligon notes.

Ligon says clinical decision aids make it less likely the EP will make a mistake. If there is a lawsuit, the EP has good justification for whatever decision they made, one that is backed up by institutional policy. An aid could build in a question such as, "Can you attempt to verify the timeline for this particular patient?"

"It's not, 'Did this start within the last three hours?' 'No. OK, done.' It's asking how was it verified," Ligon stresses.

If the patient is incapacitated, identifying the surrogate decision-maker can be problematic in the ED. "tPA is considered to be standard of care, at least according to some neurologists, so should I give it if I can't obtain consent? A faction of folks is starting to say yes," Ligon says. Some neurologists argue that tPA should be given without consent because it's the standard of care for stroke, just as an appendectomy would be performed without consent if a patient experienced appendicitis. "Our neurology colleagues are really pushing getting

this drug. But they don't necessarily want to come to the bedside to help us out," Ligon adds.

Ligon consults with neurology on almost every stroke patient.

"Often, there is nothing else to do, but I just want to make them aware, and see if they would do anything differently." ■

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Hospitals Face Liability if Impaired EP Becomes Malpractice Defendant

If a malpractice lawsuit alleges an EP was impaired by drugs or alcohol while evaluating a patient, there is potential liability for the hospital, too. "Not only is the ED physician exposed to financial and possibly criminal liability, they are exposing their employer as well," says **Adnan Sabic**, MD, an emergency medicine attending at St. John Hospital & Medical Center in Detroit.

Hospitals likely carry higher professional liability policy limits than the EP defendant. Another reason to name the hospital as a defendant: "Jurors sometimes find it easier to punish a 'bricks-and-mortar' entity, rather than an individual physician, with a sizeable verdict," says **Leslie Roberts**, director of patient safety in the risk resource department of ProAssurance. Here are some ways plaintiff's attorneys keep the hospital in the litigation against the EP:

• Arguing that the EP's impairment should have been discovered during the credentialing process.

The EP's credentialing process includes a thorough background check. Once the committee approves the appointment, it means that the facility has deemed the EP competent to practice at that facility. "It also means that the hospital stands behind that physician, and vouches for the physician's character," Sabic says. If the hospital uses contracted EPs instead of employees, the credentialing process may remain with the hospital, or it may fall on the staffing company. "The plaintiff is hoping neither will have appropriate documentation," Roberts notes. "Even better for the plaintiff is lack of documentation regarding hospital and ED policies and procedures." Especially important in these cases: relevant policies on the chain of command and impaired physicians. An EP's documented history of substance abuse is another way to keep the hospital in the litigation. "This can be presented to potential jurors as being reckless, by allowing a physician with propensity to abuse drugs to be credentialed and to work at the hospital," Sabic offers.

• Using the concept of apparent agency.

This legal construct can even apply if the EP is an independent contractor or employed by a group that contracts with the hospital. "Apparent agency is used because patients have no way of knowing the employment status of the physician. Most patients reasonably believe that the EP is employed by or is the agent of the hospital," explains **Laura Pimentel**, MD, a clinical associate professor in the department of emergency medicine at the University of Maryland School of Medicine in Baltimore. The plaintiff will look for ways to show a contracted EP *appeared* to be the hospital's employee or agent. This allows the plaintiff to name the hospital as a defendant. Roberts offers these examples:

• the physician's lab coat or scrubs bearing the hospital's name;

• a hospital-issued name tag;

• all the many signs and forms in the hospital and ED that do not explain that EPs are contractors;

• instances of other hospital staff referring to the EP as "my co-worker."

Plaintiff attorneys also can point to the fact that the hospital's board of directors grants medical staff privileges to EPs. The EPs function under the governance of the board, and are bound by the hospital's medical staff bylaws. "If the settlement value or plaintiff verdict exceeds the policy limit of the EP's liability coverage, plaintiff attorneys frequently sue the hospital for the balance, on the grounds that the EP is the apparent agent of the hospital," Pimentel explains.

The cause of action alleged against a hospital in an impairment case depends on the facts of the case and the employment status of the impaired provider, explains **Timothy D.**

Patterson, JD. "If the individual is a nurse employee, for example, the issue is more straightforward." The hospital likely bears *respondeat superior* liability for the ED nurse's actions.

"Where a contracted physician is at fault, however, the hospital may face a negligent credentialing or similar claim, targeted at the hospital's decision to allow that individual to practice in its facility," says Patterson, an attorney in the Richmond, VA, office of Hancock, Daniel & Johnson.

• Arguing that the hospital was aware of a specific impairment risk.

"The case is going to be much more significant if a provider exhibited previous problems that the hospital did not timely and properly address," Patterson warns. "That said, even first-time issues carry risk."

Hospitals typically carry an affirmative, non-delegable duty to provide a safe environment for their patients. "This means that any impaired provider — employee or not — can subject a facility to liability exposure," Patterson adds.

Impaired During ED Visit?

An EP's previous problems with drugs or alcohol could be brought into the litigation. "It very much depends on what is discoverable or in the public record," Pimentel says.

It's possible that neither the EP's employer nor the hospital was aware that a problem existed prior to an incident occurring at work. "If, on the other hand, a clinician has a history of problems that has been reported to the state medical board, a DUI, or loss of state license, this will likely be discovered," Pimentel says.

If the hospital requires drug or alcohol testing on an EP, and the test is positive, depending on state law, there may be a mandatory report to the state medical board. The plaintiff attorney likely would discover this. "In the absence of objective testing, plaintiff attorneys could depose hospital employees working with the clinician at the time of the case," says Pimentel. "They would seek evidence that the EP appeared or acted impaired."

Plaintiff attorneys seeking to prove that an EP was impaired at the time the plaintiff was seen and evaluated might face an uphill battle in the absence of objective testing demonstrating impairment. "They will likely have to establish it through testimony from other employees or patients who observed the physician's behavior," Patterson says.

If a coworker or a staff member corroborates the claim that the physician was under the influence or has observed this in the past, says Sabic, "this will go a long way to sway the jury in the favor of the plaintiff."

Defense counsel may see an opportunity to object that such testimony is speculative, or that it purports to offer expert testimony on the level of intoxication. "But on balance, those objections are likely to be deemed to go to the weight of the evidence, and the testimony will be admitted," Patterson notes. Roberts offers these strategies for hospitals trying to manage risks related to physicians, nurses, or other ED staff using drugs or alcohol or exhibiting disruptive behavior:

• Adopt zero-tolerance and no-retaliation policies;

• Define acceptable and unacceptable or disruptive behavior;

• Create a process for educating, reporting, and acting on the behavior;

• Create processes for delaying procedures until another physician or healthcare provider is available to cover the ED;

• Educate all ED staff to recognize the signs and symptoms of impairment, the risks of disruptive behavior, the hospital's culture of safety, and how and when to report physicians and other healthcare providers;

• Teach ED staff how and when to activate the organization's chain of command policy to report an impaired physician or healthcare provider. "If staff does not feel comfortable with reporting based on potential retribution or retaliation, the facility may have a bigger issue at stake: their culture of safety," Roberts warns. ■

SOURCES

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Disappointing Stroke Outcome? Patient 'Likely to Blame EP'

There are several common issues concerning ED malpractice claims involving stroke patients. **Greg Henry**, MD, FACEP, has reviewed more than 2,000 medical malpractice cases. He is clinical professor in the department of emergency medicine at the University of Michigan Medical School, former chief of the department of emergency medicine at Oakwood Hospital-Beyer Center in Ypsilanti, MI, and co-author of *Neurologic Emergencies* (McGraw-Hill Medical). Here, Henry weighs in on what he sees in such cases.

• Failure to conduct a repeat exam.

"This is one of the worst mistakes you can make," Henry warns.

He gives this scenario: A stroke patient presents within the three-hour time frame. The EP has engaged in a shared decision-making discussion with the family. There is right arm and leg and face involvement, so it's clearly an anterior circulation lesion.

For this patient, Henry says, "The only reason you do a CT is 'Blood: yes or no?' Because if you see a stroke on the CT, it's probably outside of the time window."

One ED malpractice claim involved a patient who came back from a CT scan whose family members noted he was suddenly able to move his arm.

"There is no support anywhere for giving tPA in a patient who is getting better," Henry says.

Despite this, tPA was administered to the patient, who lost consciousness. The family sued, alleging that the EP didn't re-examine the patient to see if his neurological status had changed. "If there is a positive exam and you send them for CT, make sure you re-examine the deficits again before you start the medicine. Because you will have a hard time defending it if somebody says later on, 'No, that's not the way he was at all,'" Henry explains.

• Inaccurately checking off items in EMR checkboxes.

"Write what you do, but do what you write. Don't be making stuff up, or padding the account," Henry cautions.

During one malpractice trial, it became painfully obvious that what the EP had documented was more than what anyone actually performed.

"The plaintiff attorney took this guy down the garden path," Henry recalls. The attorney started out by saying: "It says here you evaluated accommodation. Tell me the pathway of accommodation."

"You don't need that to diagnose a stroke. If all you had was accommodation, why would you be giving tPA, which is a dangerous drug?" Henry asks.

In another case, the patient's abnormal gait — or lack thereof — became a key issue. It was checked off in the EMR, but no one could back up the fact that the EP had walked the patient. The family said it never happened, and the ED nurse and technician didn't remember it happening.

"If you are going to say the patient's gait is abnormal, you better have gotten the patient off the bed and done it," Henry stresses.

• Administering tPA for posterior fossa stroke.

"Posterior fossa stroke has never been shown to be improved by tPA," Henry says. "Some research has shown benefit for tPA, but only for anterior circulation," Henry adds. "You better be prepared to defend it if you give it to someone else. If the neuro wants it given, maybe he ought to come in and give it, or you want his name and his direct order on that chart."

• Failure to transfer the patient, if needed, to meet the treatment window.

"If your hospital doesn't give tPA, get the patient out of there," Henry says. "If time is running out, you may have to start the medicine and transfer the patient."

What the EP should *not* do is hold a thorough discussion with the family and decide to give tPA without taking action.

"If all of a sudden there's this big gap in time, that doesn't make any sense," Henry notes. "Either you believe it could be effective, or you don't. If you believe it, you better give it now."

• Failure to be clear about the downside of tPA.

"Don't use the term 'magic medicine.' Because it isn't," Henry says.

Agreement to give tPA is agreement to take a chance, he says. After an honest discussion about what the drug can and cannot do, Henry says it's perfectly reasonable for EPs to give their honest opinion. Families often feel guilt when things go wrong, Henry laments.

"And when they are disappointed in the result, they are likely to blame the emergency physician." ■

SOURCE

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ED LEGAL LETTER™

CME/CE QUESTIONS

1. **Which is true regarding involuntary holding of ED patients?**

   a. If court investigators determine that civil commitment criteria for detention have not been met, the EP has a legal obligation to discharge the patient.
   b. There is no basis under EMTALA to hold a potentially dangerous psychiatric patient.
   c. Involuntary commitment statutes often offer good faith immunity where the ED clinician reasonably believes there is danger of imminent harm if the patient is discharged.
   d. Simple documentation such as "considered detention pursuant to civil commitment laws and determined patient did not meet criteria" is not enough for the EP to fall under the immunity statute.

2. **Which is true regarding legal protections for EPs involving potentially violent patients?**

   a. States are eliminating the concept of foreseeability as the standard.
   b. Recent case law rejects the need for measures, such as psychiatric evaluations, when concerns are raised about a patient's mental state.
   c. Some states are expanding civil commitment laws to include overdoses.
   d. A hearing must take place within 24 hours for a detained ED patient or the patient must be discharged.

3. **Which is true regarding liability of tPA for stroke patients?**

   a. EPs are more likely to be sued for failing to give tPA than for intracranial hemorrhage post-administration.
   b. EDs that give tPA to less than half of stroke patients probably are in violation of the community standard of care since average percentages are significantly higher.
   c. Treatment window time frames will be judged by the time of the ED order, not the time the drug was administered.
   d. Courts have ruled that tPA should be given without consent in the ED setting to patients with decision-making capacity if the patients meet criteria since it is covered under the emergency exception to informed consent.

4. **Which is true regarding legal risks of ED care provided by PAs?**

   a. ED protocols should specify which types of patients PAs can consult with the supervising EP on.
   b. By signing off on the chart, EPs are assumed to agree with the care provided by the PA.
   c. The PA should document discussions with the EP only if the EP disagreed in some way with the care plan.
   d. Supervising EPs will be dismissed from the claim unless the plaintiff produces evidence that they personally saw the patient at some point during the ED encounter.