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INSIDE

Malpractice Risks During COVID-19: 'Really Enormous' for ED Providers

Emergency department (ED) providers, overwhelmed with COVID-19 patients and at risk for contracting the virus, also face potential legal exposure.

"The legal risks to ED providers are really enormous," says **Frederick M. Cummings**, JD, an attorney in the Phoenix office of Dickinson Wright.

Many emergency physicians (EPs), ED nurses, and hospitals are stretching beyond a breaking point. "It's become clear that the medical system was poorly prepared to meet the enormous needs created by the COVID-19 pandemic," Cummings observes.

What it all means for ED malpractice claims remains to be seen. "The legal outcome of what surely will be one of the largest medical disasters in our country's history is anybody's guess," Cummings offers.

Most claims likely will come down to how well the hospital and ED providers meet the challenges created by the pandemic. To reduce legal risks during this time, Cummings says ED providers should use best practices, document reasons for exercising judgment calls, and keep updated on all recommendations. "Many liability insurance carriers are stepping up to the plate and expanding coverage in the wake of the crisis," Cummings reports.

However, the ED provider is responsible for confirming the coverage. Cummings gives these examples:

- Before EPs volunteer their services in another state, they must make sure that state has waived their licensing requirement;
- EPs should notify any applicable liability carrier of the intent to volunteer in another state in case that state has different insurance liability limits;
- ED providers should notify their insurance carriers if they are asked to provide care outside their specialty or expertise. "They may or may not be covered," Cummings adds.

It is unclear what standard of care would apply to a medical malpractice

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claim filed during the pandemic. "The standard of care is being developed in real time, as no one has faced this before," says **Megan Kures**, JD, senior attorney in the Boston office of Hamel Marcin Dunn Reardon & Shea.

Normally, it is what a similar EP would have done in similar circumstances. The problem is that there really are no "similar" circumstances. "This situation is wholly unprecedented," Kures notes. The lack of testing kits and equipment is not the fault of the ED providers, and not even the hospitals, she adds.

"Because the recommendations regarding this virus are changing frequently, the standard of care is difficult to define," says **Andrew P. Garlisi**, MD, MPH, MBA, VAQSF, medical director of Geauga County (OH) EMS and University Hospitals EMS Training & Disaster Preparedness Institute.

Garlisi says "basic, common-sense emergency department protocols should be protective. It would take a flagrant violation to trigger a malpractice action."

The most critical ED patients will be prioritized if healthcare systems become overwhelmed. "Triage decisions will then be made that will miss potentially seriously ill patients," Garlisi explains. This might include patients who are septic or those with possible heart attacks or strokes. "Under these extreme situations, it would seem reasonable that the threshold for medical/legal action would be raised significantly," Garlisi adds.

Of all the legal risks faced by ED providers right now, "the most likely claim we are going to see coming out of this situation is a failure to diagnose and admit claim," Kures says.

Available testing for COVID-19 does not provide immediate or even quick results. Whether patients actually have the infection is unknown at the time of the ED visit. "It is not always 100% clear which patients are likely to be fine with limited care and which will require aggressive supportive measures," Kures notes.

ED providers can use risk factors in making these decisions. "But there are always going to be outliers," Kures cautions.

It is not possible to admit every ED patient exhibiting symptoms, even with the potential to become seriously ill. "Even those with a presumptive positive diagnosis may be sent home if symptoms are not serious enough to warrant admission at the time of evaluation," Kures says.

EDITOR'S NOTE

Emergency department (ED) providers and hospitals face significant legal risks, some clear and others unknown, during the COVID-19 pandemic. The cover of this special issue of *ED Legal Letter* is about the likelihood of a surge in malpractice claims and why those cases might end up dismissed. Inside, we cover the legal standard of care during COVID-19, obstacles for plaintiffs who name emergency physicians as defendants, legalities if clinical practices are different from normal times, what newly enacted protections really mean for providers, allegations likely to come up during malpractice lawsuits, and what Emergency Medical Treatment & Labor Act waivers mean for hospitals.

Deciding who is sick enough to admit, and who can go home, puts the ED provider in a legally risky situation since patients could decline quickly. "If there are adverse consequences, the provider becomes an easy target," Kures says.

Hospitals face additional risks related to infection control processes. "We may see claims arising from situations where patients who are hospitalized for other reasons contract the virus from staff and develop related complications," Kures predicts.

Another obvious liability risk comes from employees who allege the hospital failed to protect them. "With the shortages of PPE [personal protective equipment] and mandates that providers reuse and limit the use of PPE, this is a real landmine for hospitals," Kures says.

Liability exposure for EDs and hospitals is going to be affected by various state and federal emergency declarations. "There are all kinds of waivers being issued. We're just wrapping our heads around the one that just came out a minute ago when the next one comes out," says **David B. Honig**, JD, an attorney in the Indianapolis office of Hall Render.

The "force majeure" legal principle is going to come into play as an overarching concept. "You can say it really isn't the provider's fault, that the crisis stems from the pandemic," Honig says. Based on this legal principle, hospitals can point at supply chain problems that left them without equipment.

Regardless of any of this, creative plaintiff attorneys can come up with many different potential causes of action against an EP or hospital. "An equally creative defense attorney will find just as many reasons why at this particular moment of crisis, there is no individual or corporate liability," Honig offers. Malpractice lawsuits still can be filed regardless of how many waivers are in effect. From there, the courts will have to sort out which can proceed and which can be dismissed. "Only after we get through this is this gigantic domino cascade of litigation going to happen," Honig says. "People who are injured are going to say, 'Where is my recompense?'"

Things might look different months or years after the height of the crisis. "We're going to return to this fantasy of normality that says, 'OK, the crisis is over now, so we can treat these claims as if this pandemic never happened,'" Honig predicts.

The defense's job will be to remind juries of the reality at the point in time of the ED care at issue. "The really interesting question is not whether people are going to sue; they are. It's how courts are going to handle it," Honig offers.

Defense attorneys can argue the pandemic was an intervening factor that shields ED providers from liability; therefore, the case should be dismissed. "The judge will either agree or will say the defense attorney gets to argue that to the jury," Honig says.

Even if cases are allowed to proceed, some allegations might be covered by waivers. If a lawsuit claims the patient should have been treated by a board-certified EP and was in fact treated by a physician from another specialty altogether, whether licensure requirements were waived will become important. "The hospital can say, 'You cannot create a tort out of a crisis when we were doing the things we were explicitly told we were supposed to do,'" Honig explains.

As for allegations that EDs should have been more prepared with staffing or equipment, the defense can prove the hospital made good faith attempts to obtain additional resources. "By definition, you can't be prepared for something that is an act of God, in legal terms. You can to some extent anticipate it, but you can't prepare for it," Honig says.

The question for ED providers becomes: How does one document that failures were the result of the crisis, rather than negligence? To some extent, it will go without saying. "It's almost hard to imagine how that doesn't happen because everybody is operating in crisis mode," Honig observes.

ED charts are not going to explain why a particular patient was kept waiting and why another patient was treated instead. "The reality is they're not going to actively document all of those triage decisions — and shouldn't, because they are too busy caring for people," Honig says.

Many ED charts are going to include minimal documentation. "Documentation as a whole is going to suffer. You are then trying to recreate things two or three years down the road," says **Matthew P. Keris**, JD, a shareholder in the Moosic, PA, office of Marshall Dennehey.

This seems advantageous to plaintiffs, but it only goes so far. Jurors and judges are likely to be sympathetic toward individual ED providers. "Honestly, I don't know if a plaintiff attorney would want that case," Keris says.

Sympathy for ED defendants likely is not just in the near term, but for the next several years. "You may be seeing the 'we were overwhelmed' defense, with staffing, documentation, supplies, general oversight of the facility, and possibly even credentialing of staff," Keris predicts.

In the months and years after the pandemic, some spurious malpractice lawsuits are inevitable. "We've all been

in ERs where somebody's grumbling with a cut finger and how they had to wait seven hours. That person with the cut finger is the one who's going to bring a lawsuit," Honig says.

It is a safe bet that plaintiff lawyers are going to pursue all kinds of claims against EDs and hospitals. "You're going to see lawyers looking for class action work, and you are going to see individuals looking for individual cases," Honig says.

As in all times of crisis, some unscrupulous lawyers and individuals are bound to try to capitalize on the situation. "Where you're going to see the big legal action is where people are trying to take advantage who, frankly, are trying to make a buck off this," Honig says. Plaintiff lawyers who pursue such cases are going to face a tough crowd in the form of judges and juries. "Doctors who typically see 100 ED patients a day and are trying to manage 300 patients are not going to be the ones the courts go after," Honig says.

Judges and juries will have lived through the pandemic, too. Defense attorneys are going to be the ones to remind them of it. "The law side has got to say to the medical side, 'You take care of people, and we'll take care of you when it's done,'" Honig says. "We'll just hope that the judges will go along." ■

Plaintiff Allegation: 'I Should Have Been Tested'

Thousands of people have presented to emergency departments (EDs) with symptoms consistent with coronavirus. Not all have been tested for various reasons.

Of those who were tested, some were discharged from the ED and never received the results. Of that group, some will die.

"If a person comes into an ED looking for a test, and it was not provided, or subsequently passes away while waiting on results, there could be lawsuits associated with that," warns **Matthew P. Keris**, JD, a shareholder in the Moosic, PA, office of Marshall Dennehey.

This is similar to malpractice claims alleging no one told ED patients about abnormal test results that came back after discharge.

"If there is a positive test, and it sits for a day and a half, that time can be very critical with some of these patients," Keris says.

Plaintiffs may try to show healthy people were tested, but someone with legitimate symptoms went untested. During discovery, the plaintiff attorney could ask for de-identified information on all other patients who received the test at the same time the plaintiff came to the hospital.

"If they find they were not as ill or dire as the person who didn't get tested, the argument's going to be 'You didn't do a good job of keeping the tests for people who legitimately needed it,'" Keris explains. One recent malpractice case involved an ED patient who left against medical advice (AMA) before abnormal lab test results returned.

"No one notified the patient, who died several days later," Keris says. The same kind of case could be made with COVID-19 tests if patients leave the ED AMA after long waits and later experience a poor outcome.

Faulting an individual ED clinician in this kind of scenario is pretty implausible.

"But if it's a system breakdown, you can blame the brick and mortar — the hospital — and not sue the individual emergency physician," Keris adds. ■

ED Care Different During COVID-19; So Is the Legal Standard of Care

Liability for emergency department (ED) providers during the COVID-19 pandemic is different than normal times.

"This is not just a disaster. This is a public health emergency that's been declared. That changes a lot of things," says **Carl H. Schultz**, MD, FACEP, professor emeritus of emergency medicine and public health and director of the EMS and disaster medical sciences fellowship at UC Irvine School of Medicine.

For ED providers, it changes priorities somewhat. Care is geared more toward the public's best interest, rather than doing the most good for one individual. "In normal times, putting two people on one ventilator would be gross malpractice," says Schultz, who also serves as the EMS medical director at Orange County (CA) Healthcare Agency.

It may be the ED is going to protocolized care and is going to be giving tissue plasminogen activator instead of taking patients to the cath

lab. In a public health emergency, EPs must do the best they can with the resources they have to maximize survival the best they can. "That becomes the standard of care," Schultz notes.

The standard of care is not static. "As circumstances change, what a reasonable EP [emergency physician] would do under those circumstances changes," Schultz says. For instance, confronted with a public health crisis, a reasonable EP would not be expected to endanger his or her own health.

Basically, the standard of care in a pandemic is the same as in "normal" times, says **Mark A. Rothstein**, JD, founding director of the University of Louisville Institute for Bioethics, Health Policy and Law. It still is defined as the level of care that would be provided by a reasonably prudent physician in similar circumstances.[1]

"The key is 'in similar circumstances,'" Rothstein underscores. "Healthcare providers are not held to a standard of doing the impossible."

EDs are not expected to provide the same level of care that would be reasonable during normal times. "This same flexible standard applies to the treatment of a patient with COVID-19 or any other medical condition," Rothstein explains.

For this reason, says Rothstein, "despite great concern about malpractice or negligence liability, there are very few cases that have been brought alleging substandard care during a public health emergency."

Ordinarily, care standards require EPs to meet certain medical needs for patients. But during a pandemic, standards may have to shift to help the larger community, according to **Sarah Wetter**, JD, MPH, a law fellow at the O'Neill Institute for National and Global Health Law in Washington, DC. Crisis standards of care are defined as the "optimal level of care that can be delivered during a catastrophic event, requiring substantial change in usual healthcare operations."[2]

"Under crisis standards of care, the legal system can support and encourage healthcare workers by affording them freedom from retroactive legal scrutiny," Wetter says.

When EDs shift to crisis standards of care due to constraints on resources, personnel, and time, "it becomes justified to focus on the needs of the population in crisis, rather than the individual," Wetter says.

Most states have instituted emergency laws that allow governors to waive liability for healthcare professionals and organizations that are partaking in emergency management.

"There are usually exceptions for malicious, willful, or reckless conduct that results in injury or death," Wetter observes.

According to Schultz, "if anything, the crisis is legally protective. Emergency physicians are much more likely to be sued in peacetime for simple things that they screwed up on rather than during a disaster."

During previous disasters, there has never been a successful malpractice action taken against a provider who had not engaged in gross negligence, according to the authors of a literature search.[3] After Hurricane Katrina, legal action was taken against a physician in New Orleans.

"But it wasn't tort law. The doctor was accused of euthanasia, which is a criminal offense, and was acquitted anyway," Schultz notes.

Similar litigation patterns are found in the aftermath of other disasters. "To give a broader picture, this isn't the first disaster we've had in this country. We've had many," Schultz notes. "In environments of disaster, physicians tend to be supported over and over again."

Judges and juries have been reluctant to issue verdicts of negligence or malpractice in such cases. After the COVID-19 pandemic, it will not be hard for the defense to convince anyone that EPs were working in horrendous conditions.

"There's very little chance a physician will run into trouble when providing reasonable, prudent care in the context of a public health emergency," Schultz predicts.

Successfully proving the three elements of negligence also is a problem in terms of causation. "You have to prove that your action was the proximate cause of whatever happened," Schultz says.

If an EP could not move a patient upstairs to an intensive care unit bed because there were none available, then the EP was not the proximate cause. The pandemic was.

"This is not a hard concept for anyone to understand," Schultz explains. ■

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Crisis Changes Priorities — and Possibly Clinical Practices

There is a tipping point for any emergency department (ED) when the normal standard of care is no longer possible. As the COVID-19 pandemic unfolds, some EDs are coming close to reaching it.

"I am concerned we might end up getting to the point where we will change the standard of care," says **Robert B. Takla**, MD, MBA, FACEP, a Detroit-based emergency physician (EP).

Hospitals are moving from conventional care to contingency care. For example, when intensive care units (ICU) are full, another 20% of patients still can be accepted into other areas, such as the post-anesthesia care unit or the stepdown, and still receive ICU-level care. Things change once the hospital exceeds 120% of conventional care, both in terms of space and resources. "Then, we approach a crisis standard of care. That's when we may have to do things dramatically differently," Takla notes.

For ED providers, appropriate interaction with the local emergency management and healthcare coalition is essential during this time. "They often provide additional resources and help prevent going into crisis," Takla says.

Many EDs have created drive-up screening areas for anyone who presents with nonemergent complaints. EDs staff still perform a medical screening exam (MSE) on all patients, as required by the Emergency Medical Treatment & Labor Act. If an emergency medical condition is present, the patient needs more intervention and testing. "But with some patients that we would normally consider for further diagnostic testing or treatment in the ER, we have to think really hard about if that is what is safest for the patient today," Takla adds.

That is because by bringing somebody into the building, ED providers are putting the patients at greater risk. For this reason, if someone appears stable, and the MSE uncovers no emergency medical condition, they are, in general, released, advised to follow up with their primary care physician, self-monitor, and return if their condition worsens.

"You have to think of the entire ER as one giant microbiome. It's not as safe for them to be in the ER as it was, say, three months ago," Takla observes.

Providers explain the situation in the ED and hospital to patients if they think coming into the department could do more harm than good. EPs use informed shared decision-making. "Trying to do what is best for the patients, under these challenging conditions, is a tricky scenario," Takla acknowledges.

Normally, defense attorneys want ED charts to include reasons for any possible deviation in the standard of care. "I feel there is going to be at least a little bit of slack given," says **Tiffany S. Hackett**, MD, MBA, director of leadership development at Vituity, an Emeryville, CA-based provider of medical staffing services and hospital solutions.

Documenting all kinds of specifics on what should have been done for an ED patient, but was not, could look overly defensive, as if the EP knew care was substandard. "If something were significantly changed with how we care for the patient, I would describe it, and address why" says Hackett, who also works as an EP. "But in general, if you are doing the right thing for the patient, you're going to be fine."

Since ED practices are changing daily based on various factors, documentation could be a valuable reminder of why something was handled differently. "Literally, it could be that one day we are doing it this way, and the next week we do it another way," Hackett says. For instance, the criteria for who is tested changes as kits become available and EDs learn more about who is becoming infected.

During the COVID-19 pandemic, care of other ED patients may differ from what it would have been in normal circumstances. Here are some examples:

- **Some patient histories are conducted by phone instead of at bedside.** If something important is missed, it might help the defense to note how the history was taken. "I would put that in my chart. It might be helpful to state something like, 'Per current ED procedures, this is the way we are doing things,'" Hackett offers.
- **Patients could end up receiving delayed care for time-sensitive conditions such as a heart attack or stroke.** "If that heart attack patient had a fever, there would be some — but not huge — delays," Hackett says.

The cath team might not go down to the ED, and the electrocardiogram might be obtained without the EP going into the room. "It's not ideal. But there's a lot we can do without having to go into the room with the patient," Hackett notes.

With acute stroke patients, neurologists are discussing initial consults on a telehealth screen to

avoid coming into the ED. "As long as we are communicating, there shouldn't be significant delays," Hackett adds.

• **There could be delays in intubation.** Recently, a code blue was called for a COVID-19 patient in the ICU. This raised concerns about protecting providers who are performing CPR and using bag valve masks to ventilate patients.

"Those are potential life-saving interventions where you can aerosolize the virus," Hackett says.

The code blue team cannot proceed without appropriate personal protective equipment (PPE). Even with everything ready to go outside the room, says Hackett, "it still takes a few solid minutes to don everything, and you generally need people to assist."

• **EPs limit the number of times they enter patient rooms.** "We've had conversations about being judicious with PPE," Hackett says.

To conserve PPE, EPs are limiting the number of times they go into rooms to avoid changing gowns and gloves multiple times. "We try to go in there only once, unless the patient needs emergency intervention," Hackett explains.

• **For patients with symptoms suggesting COVID-19, staff still may overlook other medical conditions.** "We are focusing so much on COVID-19 that we need to remember that shortness of breath and fever could also be due to pneumonia, or a [congestive heart failure] or [chronic obstructive pulmonary disorder] exacerbation," Hackett cautions.

• **Patients with shortness of breath cannot always receive the care they normally would.** "There are some very effective treatments that we use in the prehospital setting and the ER to manage somebody with acute shortness of breath," Hackett says. Nebulizers and bilevel positive airway pressure machines can alleviate the need for ventilators in some patients.

"The problem with both of those devices is that they aerosolize the droplets if somebody has COVID-19 or another infection," Hackett laments.

Asthmatic or older heart failure patients struggle to wean off the ventilator. "You want to avoid it, if possible. But the treatment is not allowed to be used for safety reasons when we suspect COVID-19 infection may be a part of the clinical picture," Hackett reports.

Some hospitals are asking ED providers not to use these treatments if the patient is suspected to have COVID-19 infection. If a nebulizer is not used for safety concerns, Hackett suggests EPs chart something like: "In light of the current COVID-19 pandemic and concern that the patient may have this infection, the patient was treated with an inhaler and not nebulized."

• **Not all ED patients are going to be protected from infection.** Anyone walking into an ED right now could contract COVID-19 from another patient, visitor, or ED provider. If the hospital failed to isolate infected patients, it could face allegations of negligence.

"We want to make sure we separate the upper respiratory infection patients from other patients, especially older patients with comorbidities. That's one thing we need to be worried about," Hackett underscores.

It would be pretty tough to prove anyone contracted COVID-19 from someone in the ED. However, since the virus is everywhere in the community, "that could be contended, but it would be hard to prove. It would be hard to envision how a patient could successfully bring a malpractice suit against a hospital," says **David Talan**, MD, FACEP, FIDSA, chair emeritus of the department of emergency medicine and faculty in the division of infectious diseases at Ronald Reagan UCLA Medical Center in Los Angeles.

A plaintiff might be able to prove the hospital was negligent in the way they screened, handled, and isolated COVID-19 patients.

"But it would be hard to prove that any healthcare worker or patient actually contracted it through those means," Talan explains.

If a patient was not handled correctly, and a cluster of ED staff all contracted the virus while caring for that particular patient, "it wouldn't be proof. But it would be closer," Talan says.

It could give a jury sufficient reason to surmise that an ED provider contracted COVID-19 because of the hospital's negligence.

"If there's generally a shortage of equipment, though, I don't know how you'd blame the hospital," Talan adds.

The plaintiff would need to show the equipment was available at the time. "They would also need to show that the hospital didn't go to reasonable lengths to procure it," Talan says. ■

COMING IN FUTURE MONTHS

- Hospitals face lawsuits from infected ED providers
- Legal risks for ED if no ICU bed available for patient
- Unified tactics for co-defendants in COVID-19 claims
- Liability issues if ED physicians volunteer out of state

Protections Enacted for ED Providers, but 'Liability Changes Every Day'

There are states that have issued various executive orders to reduce liability of providers during the COVID-19 pandemic, but legal protections continue to evolve.

"Liability changes every day, depending on the developments in the regulatory infrastructure," says **David S. Waxman**, JD, a partner in the Chicago office of Saul Ewing Arnstein & Lehr.

Evaluating what all the state and federal protections really mean for emergency department (ED) malpractice claims is not clear. "It's a complicated question," says **Sharona Hoffman**, JD, co-director of the Law-Medicine Center at Case Western Reserve University in Cleveland.[1,2]

Some states offer broad immunity protections once a public health emergency is declared, and others do not. For instance, under Maryland law, a healthcare provider is immune from civil or criminal liability if the provider acts in good faith and under a catastrophic health emergency proclamation. "That would provide you with pretty broad coverage for a lot of scenarios. But other states don't have that kind of protection," Hoffman observes.

Even if an emergency physician (EP) is working in a state without a broad law in place, judges still will take the circumstances into account. "But it's up the judge, it's up to the jury. You never know what they are going to think," Hoffman cautions.

Documentation of a huge surge of COVID-19 patients could bolster the odds of malpractice claim dismissal for an individual. "In the chaos of all of this, it's not going to be possible to remember what was going on at a given day or hour," Hoffman notes. Existing protections should cover care of non-COVID-19 patients, too. "It's understood you're going to have mayhem, whether it's a broken leg, a heart attack, or COVID-19," Hoffman explains.

The main message for EDs and hospitals is that months or years down the road, despite any protections that may be in place, "there still could be malpractice litigation," Hoffman underscores.

Meanwhile, states are continuing to issue immunity provisions. New York and Illinois have granted immunity to care providers with the exception of gross negligence.[3,4] "While this is not an elimination of potential liability, it is a material raising of the bar, and makes it considerably more difficult for malpractice plaintiffs to prevail," Waxman says.

The overriding question in all of this is to what degree the public health crisis will be taken into account when malpractice litigation is filed months or years from now. "One of the things that we won't know for some time is whether the unfortunate but foreseeable health outcomes will result in a corresponding spike of litigation," Waxman says. "You would like to think that the answer is no."

There are many well-intentioned efforts to protect ED providers, but none offer absolute immunity. "The argument would be that there can't be, because there are certain acts that should never be immune for a lawsuit," Waxman says. Another unknown is how courts will interpret any of these orders or waivers. The New York executive order states there is absolute immunity (no liability) for lack of charting due to the crisis. But it is unclear what this really means in terms of legal protection.

"You start from the premise that the best ammunition any malpractice defendant is going to have in any case is well-reasoned documentation, done at the time the care was provided," Waxman explains.

Current circumstances in EDs may prevent careful charting. For example, a lawsuit might allege the plaintiff waited too long to be moved to the intensive care unit (ICU). The ED chart does not say there were no ICU beds available, does not indicate that there was a tremendous backlog of patients in the ED at the time, and does not mention the lack of available personal protective equipment that prevented a proper exam. "If that's not charted, while you may not be liable for not making an appropriate entry in the chart, it's not going to help you in the malpractice case where the issue is whether the care complied with the governing standard of care," Waxman offers.

Other patients could allege delays happened because ED providers were overly focused on COVID-19 patients. Plaintiff attorneys are narrowly focused on the care one individual patient received. "The demands on the institution at that time are not really their concern," Waxman says.

A stroke patient who does not receive tissue plasminogen activator because of a long wait for evaluation is a good example. "Generally speaking, a provider who is flooded with COVID-19 emergencies is not immune from criticism coming from a non-COVID-19 patient," Waxman says.

The bottom line is that none of the legal protections for ED care are foolproof. "The hope is that the goodwill that currently extends to the

care providers will still be there by the time these cases come into fruition," Waxman adds. "There is no way to know until the litigation comes." ■

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Hospitals Are More Appealing Defendants Than Emergency Physicians

Even in normal circumstances, it usually is easier for a plaintiff attorney to criticize a big, impersonal hospital corporation than a practicing emergency physician (EP).

"That's even more the case, probably exponentially more, when the potential emergency physician defendant is working double shifts with their own health imperiled," says **David S. Waxman**, JD, a partner in the Chicago office of Saul Ewing Arnstein & Lehr.

No plaintiff attorney wants to make an EP the target of a lawsuit when there is a much more appealing defendant: the hospital. "The one calculation that the plaintiff bar is going to have to make here, and this may change over time, is that emergency physicians are heroes for stepping up and doing what they are doing in absolutely impossible circumstances," Waxman says.

Plaintiff attorneys will look for the easiest target to maximize compensation for their clients. "That's not going to be a heroic care provider who can put a face on this crisis," Waxman adds.

For hospitals, legal risks stem from "inaction rather than action," says **Danielle M. Trostorff**, Esq., a health law specialist at Degan, Blanchard & Nash in New Orleans. Hospitals can get into legal trouble by failing to train staff, or failing to take recommended precautions. "Liability is in not responding to the unique needs attendant to this pandemic."

For hospitals following known Centers for Disease Control and Prevention guidance and taking necessary precautions, liability should be minimized. But staffing is another possible source of liability. "Staffing is always an area highlighted in medical malpractice cases," Trostorff observes. "Plaintiffs like to argue staffing was inadequate."

If the hospital is following staffing rules, the plaintiff is unlikely to succeed on that argument. "A hospital would argue they were in crisis mode and cannot be responsible for staffing," Trostorff explains.

Hospitals usually adjust staffing based on census. "The hospitals are adjusting, and are working not only to increase beds to meet the increased need, but also utilizing staff from all available resources to meet the increased demand," Trostorff says.

Even if the plaintiff proved a hospital did not do enough to ensure adequate staffing, there is another hurdle. "The plaintiff still has to prove that's what caused a bad result," Trostorff notes.

Some hospitals post emergency department (ED) wait times online. To some extent, this could refute allegations involving delayed care. "An individual is forewarned, and can go to another facility with shorter wait times," Trostorff offers.

If there was no ED with shorter wait times, the plaintiff cannot

allege the hospital was an outlier. "The hospital can't be held to a higher standard because there is a pandemic," Trostorff argues. "While they certainly need to adjust for expected volumes to the extent they are able, that can't always occur."

Just as it does for an individual EP, the legal standard of care to which hospitals are held varies along with the conditions and circumstances.[1] Physicians are required to act as a reasonable EP would in the same or similar circumstances. This also applies to hospitals. "But it might be more difficult to get an expert to testify as to what a 'reasonably prudent' hospital would have done, faced with a coronavirus pandemic," says **George J. Annas**, JD, MPH, director of the Center for Health Law, Ethics & Human Rights at Boston University.

It is possible that some ED patients will be seen by volunteer physicians outside the specialty. Annas says these two questions will arise if someone alleges only an EP should have treated the patient who presented to the ED:

• Does the patient have a right to know the qualifications of the non-ED physician? Even if the answer is yes, says Annas, "whether anyone would refuse treatment under these circumstances seems unlikely."

• Would a reasonable hospital have used non-ED-trained physicians under the circumstances? "The latter will depend upon what choice, if any, the hospital had, short of closing the ED," Annas says. ■

REFERENCE

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EMTALA at Issue During COVID-19

The COVID-19 pandemic "is a rapidly changing situation, resulting in constantly changing governmental announcements and potentially changing legal requirements," notes **Stephen A. Frew**, JD. That includes the Emergency Medical Treatment and Labor Act (EMTALA).

EMTALA requirements "can pose serious obstacles to reasonable care in the event of a disaster or public health emergency, such as the current coronavirus outbreak," says Frew, vice president of risk consulting at Johnson Insurance Services and a Rockford, IL-based attorney. At press time, "EMTALA remains in full force and effect," Frew emphasizes.

The law does provide for emergency waivers of some EMTALA requirements in circumstances in which the federal government responds to state or national declarations of disaster or public health emergency.

"The waivers are not automatic, and may require individual hospitals to apply for waivers on a case-by-case basis," Frew cautions. Here are some developments and what it means for EDs:

• An EMTALA guidance for hospitals was issued on March 9 by the Centers for Medicare & Medicaid Services (CMS).

This guidance says hospitals could designate separate on-campus "alternate screening sites."[1]

The guidance also stated that hospitals could set up off-site locations and encourage the public to use them.

"But, absent the necessary HHS [Department of Health and Human Services] waiver, the hospital could not redirect patients to these off-site centers," says **Carrie Valiant**, JD, an attorney with Epstein Becker Green in Washington, DC.

• In response to President Trump's declaration of a national emergency on March 13, as well as various state declarations, HHS authorized CMS to consider several waivers of federal laws, including EMTALA.[2]

"Unfortunately, while the language appears broad at first glance, there is limiting language, suggesting that both CMS and the state may need to take further action to implement the waivers," Valiant cautions.

To actually take effect, the EMTALA waiver seemingly will require CMS to make state-by-state or even hospital-by-hospital decisions.

"Federal waiver letters have gone out to a number of states. But none of them include EMTALA waivers to date," Frew notes.

• CMS issued a blanket waiver to allow moving patients offsite for screening.[3]

"Note that this is a very limited waiver of EMTALA. All other EMTALA requirements appear intact at this time," Frew underscores.

The HHS waiver applies "only to the extent necessary" as determined by CMS. It applies only "pursuant to an appropriate state emergency preparedness plan."

"It does not appear that CMS has yet determined the extent to which the EMTALA waiver is necessary on a blanket basis, or the process by which it will determine necessity,"

Valiant adds. Basically, it is unclear whether individual hospitals or states must specifically request a waiver, or whether the "blanket" waiver covers them. It also is unclear whether alternate sites can be directed only by the state, pursuant to the state plan.

The lack of clarity has confused and frustrated ED providers and those advising them.

"What more could possibly be needed to demonstrate need for the waiver that isn't already apparent?" Valiant asks.

Clarifying guidance as to the meaning of the language of the waiver is critical to enable hospitals on the front lines of the pandemic to do what is necessary to treat patients while preventing further spread of the virus, Valiant says.

"Faced with a clash between patient health and safety and EMTALA, hospitals generally choose patient care," Valiant observes. "They shouldn't have to make a choice."

The HHS announcement indicates federal penalties may be waived for certain technical requirements of EMTALA, unless there is fraud or abuse.

It specifically states that CMS may choose not to assess penalties arising out of "the direction or relocation of an individual to another location to receive medical screening pursuant to an appropriate state emergency preparedness plan or for the transfer of an individual who has not been stabilized if the transfer is necessitated by the circumstances of the declared federal public health emergency for the COVID-19 pandemic."[2]

This language would allow hospitals to activate their disaster or public health emergency plans for triage, diversion, or transfer of patients, without some of the formal EMTALA compliance activities. "The waiver does not, however, prevent CMS from initiating investigations where it appears the hospital may have violated EMTALA," Frew says.

If someone complains a hospital is refusing infected patients, CMS could be expected to trigger an investigation in the thick of the pandemic.

The same is true if someone complains an ED is discriminating against patients on the basis of financial means or ability to pay, or if ED providers are violating the local or state pandemic regulations.

Frew says experience and CMS directives suggest investigations are unlikely during the midst of a declared emergency, without some indication that hospital practices pose a threat to life or safety of patients.

Still, none of the waivers mean ED providers can just forget about EMTALA obligations. "CMS has issued citations for violations of EMTALA in major disasters," Frew reports.

One hospital was cited for a technical EMTALA violation in the middle of Hurricane Katrina. The hospital remained open during the storm, despite massive damage that disabled most of its capabilities. When an ambulance arrived with a nursing home patient, the triage officer reportedly waved the ambulance off and instructed it to go elsewhere, not realizing all roads out of the area were closed. The ambulance returned to the nursing home, where the patient died.

"While CMS did not investigate this case during the actual hurricane, inspectors arrived days later, shortly after roadways were opened to access the hospital," Frew says.

In that particular case, the citation was later rescinded by congressional intervention. Nonetheless, it is a cautionary tale for hospitals.

"It is advisable to follow standard EMTALA compliance policies and procedures unless that would place lives in jeopardy under the emergency circumstances," Frew underscores. ■

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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;
3. Integrate practical solutions to reduce risk into daily practice.

ED LEGAL LETTER™

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CME/CE QUESTIONS

1. **Which is true regarding the standard of care during a public health emergency?**
   a. ED care is geared more toward the public's best interest, rather than doing the most good for one individual.
   b. Despite changing circumstances, emergency physicians (EPs) are expected to provide the same level of care that would be reasonable at any other time.
   c. The standard of care is no longer defined as the level of care that would be provided by a reasonably prudent physician in similar circumstances.
   d. Plaintiffs tend to prevail in cases alleging substandard care during a public health emergency.

2. **Which is true regarding emergency department (ED) providers who volunteer their services during a public health emergency?**
   a. Varying insurance liability limits prevent most ED providers from offering services out of state.
   b. ED providers should notify their insurance carriers if they are asked to provide care outside their specialty or expertise.
   c. States are required to waive licensing requirements during the pandemic.
   d. Insurance carriers are required to cover ED providers for any care administered outside their specialty during disasters.

3. **Which is true regarding malpractice lawsuits involving care rendered during disasters?**
   a. Plaintiffs tend to be supported by judges.
   b. Juries have been reluctant to issue verdicts of negligence or malpractice in such cases.
   c. Causation becomes significantly easier to prove.
   d. ED care is more likely to be viewed as grossly negligent.

4. **Which is true regarding state and federal protections for ED malpractice claims?**
   a. States offer only narrow immunity protections for ED providers.
   b. Existing protections explicitly exclude non-COVID-19 patients.
   c. Generally, state liability waivers exclude gross negligence.
   d. Documentation requirements for ED care increase during public health emergencies.