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Errors at triage– don't get off on the wrong foot

By: **Jay C. Weaver, ALB, JD, EMT-P**, Attorney, Adjunct Faculty, Northeastern University Institute for Emergency Medical Services, Boston.

Editor's Note: *Triage is where the duty to the patient begins. Once a patient enters the doors of the emergency department (ED) and presents for treatment, there is an obligation to perform a screening examination and treat any emergency medical condition that is discovered. The triage examination and any subsequent examination must be performed at an acceptable standard of care. These patients are protected by the rules of professional negligence and the Emergency Medical Treatment and Active Labor Act (EMTALA). The dangers of triage include not only delays in the recognition of life-threatening illnesses, but inappropriately allowing patients to leave prior to treatment. The author presents several cases of triage negligence which led to costly malpractice judgments. Use of these risk management strategies provides an effective means to reduce errors in triaging patients.*

Triage refers to the process of sorting patients according to need.[1] Derived from the French verb *trier*, meaning "to pick or to sort," this term originally described a type of battlefield hospital.[2] After World War II, the United States military used triage to distinguish wounded soldiers capable of returning to battle from those who required immediate evacuation.[3] ED personnel today employ triage as a means of rapid patient assessment.[4] Rather than caring for patients in the order of presentation to the ED, hospitals seek to identify and treat the most critical cases first, thereby ensuring that true emergencies receive timely attention.[5] In the past, physicians, nursing assistants, and even receptionists performed this task.[6] Today, responsibility for triage falls almost exclusively within the domain of the registered nurse.[7]

Even with all of the diagnostic tools available to the modern ED, triage does not yet constitute an exact science, however. Pressured to make immediate decisions in a chaotic environment, and forced to rely solely on information obtained

during a cursory physical examination, ED personnel cannot classify incoming patients with perfection.[8] Serious conditions sometimes go overlooked, and patients have died in hospital waiting rooms for want of timely care.[9] It is not uncommon, then, for civil actions to arise as a result of the triage process, particularly when the plaintiff perceives a delay in emergency treatment as the cause of the patient's demise.

Lawsuits premised on inadequate triage generally take two forms. Historically, plaintiffs have framed improper triage as a form of medical malpractice.[10] In cases where patients died, the actions generally became ones for wrongful death.[11] In recent years, however, plaintiffs injured by the triage process have brought suit with increasing frequency under EMTALA.[12] Passed in 1986, this statute requires hospitals participating in the Medicare program to provide a screening examination to each person requesting one, and to stabilize any patient found to be suffering from an emergency medical condition or active labor.[13] While the courts have consistently held that EMTALA does not create a separate federal malpractice claim,[14] these causes of action overlap, and plaintiffs often advance EMTALA claims and state medical malpractice claims together.[15]

Common Law Duty of Care

The common law has never imposed a duty on private hospitals to serve every patient seeking emergency care.[16] To the contrary, hospitals traditionally have accepted or rejected patients virtually at will.[17] Over the years, a minority of states have imposed a statutory obligation on hospitals to provide emergency treatment as a condition of licensure.[18] Courts in other states have construed licensure as creating a public duty to render emergency care.[19] For the most part, though, hospitals still have a duty to triage incoming patients only to the extent required by EMTALA.

Once a hospital voluntarily accepts a patient for treatment, however, it thereafter incurs a duty to act with due care.[20] The patient need not be formally admitted before such a duty arises.[21] Rather, a duty of due care may arise from the mere evaluation of a patient during the triage process. In *South Fulton Medical Center v. Poe*, for example, the Georgia Court of Appeals held that a duty of reasonable care existed as soon as a nurse examined an infant at triage.[22] Acting on the triage nurse's suggestion that the "baby was doing ok," the parents took the child home without treatment, and the infant died a short time later.[23] On appeal, the hospital argued that liability did not exist because the infant never became a patient of the hospital.[24] The appeals court dismissed this contention and affirmed the jury verdict of $1.85 million.[25] Similarly, in *Hunt v. Palm Springs General Hospital*, the Court of Appeal of Florida held that a hospital owed a duty of care to an unadmitted patient left suffering seizures in a hallway while the patient's private physician arranged transfer to a different facility.[26]

A hospital may assume a duty of reasonable care as well from the initiation of treatment by its ED staff during the triage process. In *Citizens Hospital Association v. Schoulin*, a nurse conducted an initial examination of a car-accident victim in the ED.[27] Acting on information provided by the nurse over the telephone, a physician outside the hospital prescribed codeine for the patient's back pain.[28] The patient later claimed that the nurse had manipulated his legs, causing numbness in his lower trunk and extremities, and that the doctor had

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Editorial Group Head: Valerie Loner
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Customer Service E-Mail Address: customerservice@ahcpub.com
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negligently diagnosed and prescribed treatment for his broken back.[29] Like the hospital in *South Fulton*, the defendant hospital and physician argued on appeal that negligence liability failed to exist for want of duty, since the injured man had not become a patient of the hospital as of the time of examination.[30] The appeals court affirmed the jury verdict in favor of the plaintiffs. In so doing, the court announced that the triage nurse "could have met appellee at the door of the hospital and said we cannot take you in, you must go, and the hospital would have been acting within its rights, but that is not what happened. Appellant acted and thereby came under an affirmative duty to exercise reasonable care in the performance of its undertaking."[31]

Hospital treatment policies, too, may create a duty of care. On Aug. 16, 1983, a mother entered the Huntsville Hospital in Alabama, seeking treatment for her 15-day-old son's fever.[32] The admitting clerk told the mother that the hospital would not treat her infant unless she produced evidence of insurance or a $54 fee.[33] The mother left, but returned to the hospital later that evening after the infant's condition did not improve.[34] This time, a doctor examined the infant and admitted him to the hospital, but the boy later died of spinal meningitis.[35] In the wrongful death action that ensued, the defendant hospital moved for partial summary judgment, claiming that it had no duty to accept the infant as a patient.[36] The trial court granted the motion,[37] but the Supreme Court of Alabama overturned it[38] on grounds that the hospital's policy of admitting all patients who "arrived in an emergency condition"[39] provided a scintilla of evidence from which a jury could infer that the hospital owed the plaintiff a duty of reasonable care.[40]

A hospital that voluntarily opens its doors to emergency patients may breach its duty of care at triage in a number of ways. Liability most commonly arises from the untimely identification or correction of an emergent condition. As the following case illustrates, the failure of ED personnel to rapidly and accurately assess the severity of a patient's illness may produce a delay in treatment, which in turn may create fertile ground for a medical malpractice action.

Case #1

Feeney v. New England Medical Center [41]

Shortly after 10 p.m. on Dec. 1, 1987, emergency medical technicians (EMTs) of Boston's Department of Health and Hospitals discovered a 26-year-old man, Brian Feeney, sitting on a street corner, speaking incoherently. Believing Mr. Feeney to be drunk, the EMTs attempted to examine him and to take vitals signs, but they abandoned these efforts when the patient became combative. Mr. Feeney admitted that he had been drinking prior to the arrival of the ambulance. Indeed, as the appeals court later noted, "No observer could doubt that the patient had taken deeply of ethanol." [42]

The EMTs brought the patient by ambulance to the ED of the New England Medical Center.

A nurse examined Mr. Feeney at triage, and found him to be "responsive to pain, and able to speak and move his extremities."[43] The nurse's report does not reflect that anyone took Mr. Feeney's vital signs. ED personnel placed Mr. Feeney on a stretcher in a hallway between the waiting room and the treatment area, where he remained unattended for the next 20 minutes. When a nurse finally wheeled Mr. Feeney into an examination room, the ED staff found him unresponsive and in respiratory arrest. Physicians and nurses attempted resuscitation for approximately 30 minutes, but a doctor pronounced Mr. Feeney dead at 12:07 a.m.[44]

Mr. Feeney's father later brought a medical malpractice action against New England Medical Center, the ED physician, and the nurse who had performed the triage.[45] A medical tribunal consisting of a physician, judge, and attorney found the plaintiff's offer of proof insufficient, and since the plaintiff could not produce the statutorily required bond, a judge dismissed the complaint.[46]

The plaintiff appealed the tribunal's decision. Finding that a doctor-patient relationship existed as soon as the hospital received the patient, and that the plaintiff's showing of negligence and causality should have survived the tribunal, the Massachusetts Appeals Court overturned the dismissal and reinstated the medical malpractice complaint.[47] In rendering its decision, the appeals court relied heavily on the testimony of expert witnesses. A nurse testified that the ED staff should have monitored Mr. Feeney's pulse and respirations every 15 minutes[48] and that doing so would "likely have permitted the nursing staff to observe changes in [Mr. Feeney's] breathing patterns, or the onset of respiratory arrest." [49] According to a clinical pharmacologist, the physician on duty in the ED had an obligation to determine who was waiting for care and how critically each patient needed that care.[50] The nurse and pharmacologist both testified that if the ED staff had

adhered to these standards, Mr. Feeney's respiratory arrest likely would have been detected earlier, and his death, therefore, might have been avoided.[51]

Hospitals breach their duty of care not only when they fail to detect critical conditions at triage — as the plaintiff alleged in *Feeney* — but also in failing to provide adequate care while the patient waits for examination and treatment by a physician. Triage personnel cannot simply categorize patients as they come through the door and then ignore them until a physician becomes available to initiate care. Rather, the ED staff must constantly monitor the condition of each patient and provide appropriate intervention during the triage process and beyond.

The fact pattern in a Louisiana Court of Appeal case, *Gordon v. Willis Knighton Medical Center,*[52] reveals a particularly egregious breach of this duty. Here, the failure of the defendant hospital's ED staff to monitor and treat a critically ill patient was so profound that the appeals court took the extraordinary step of rendering judgment notwithstanding the verdict on the grounds that the jury's findings were manifestly wrong.[53]

Case #2

Gordon v. Willis Knighton Medical Center [54]

On Feb. 14, 1988, 76-year-old Elizabeth Gordon experienced chest pain and difficulty breathing while playing bingo at a Knights of Columbus Hall. Paramedics of the Shreveport (LA) Fire Department responded to the scene, recorded Ms. Gordon's vital signs, administered oxygen, and performed electrocardiography. The paramedics then transported Ms. Gordon by ambulance to the Willis Knighton Medical Center, where, despite the ominous nature of Ms. Gordon's complaints, ED nurses immediately discontinued the oxygen and cardiac monitoring initiated in the field.[55]

Notified by a family friend that Ms. Gordon had gone to the hospital, the patient's children drove to Willis Knighton and inquired at the ED desk about their mother's condition. A receptionist denied that Ms. Gordon was a patient there. Ms. Gordon's children drove back to the Knights of Columbus Hall, where acquaintances confirmed that Ms. Gordon had indeed gone by ambulance to Willis Knighton. Ms. Gordon's children returned to Willis Knighton, but the same ED receptionist continued to insist that Ms. Gordon had never arrived. Ms. Gordon's son initiated a room-by-room search, and eventually found his mother alone in an examination room, fully clothed, receiving no oxygen, not connected to a cardiac monitor.[56] An ED nurse later disputed the son's claim that Ms. Gordon was not attached to a cardiac monitor, but the nurse admitted that he could not recall whether the monitor was equipped with an alarm.[57]

Ms. Gordon's son went to the reception desk, informed the attendant that he had located his mother, and requested assistance. When he returned to his mother's room, his mother complained of indigestion-type chest pain. As the son attempted to assist his mother into the bathroom, Ms. Gordon suddenly collapsed and fell back onto the bed. The son ran into the hallway screaming. A nurse summoned an emergency physician and a cardiologist, but resuscitation efforts failed and Ms. Gordon died at 9:15 p.m.[58]

Ms. Gordon's children initiated wrongful death and survival actions against Willis Knighton Medical Center under a theory of medical malpractice.[59] At trial, a board-certified internist, Dr. Robert Hernandez, testified that the hospital should have classified Ms. Gordon as an urgent cardiac patient at triage.[60] According to Dr. Hernandez, a nurse should have evaluated Ms. Gordon immediately, and a doctor should have examined her within 15 minutes of arrival in the ED. Dr. Hernandez went on to testify that Willis Knighton's ED personnel should have kept Ms. Gordon on oxygen, and that they should have attached her to a cardiac monitor with an alarm. Failure to do so, Dr. Hernandez testified, increased Ms. Gordon's likelihood of suffering a heart attack and decreased her chances of survival.[61] Four other doctors gave similar testimony.[62]

A jury determined that Willis Knighton Medical Center did not breach the applicable standard of care regarding its treatment of Elizabeth Gordon.[63] The trial court dismissed the suit and denied the plaintiffs' motion for judgment notwithstanding the verdict.[64] The appeals court took an entirely different view of the evidence, however. Reversing the decision of the trial court, the Louisiana Court of Appeal noted that:

"It is undisputed that Ms. Gordon should have been classified as an urgent cardiac patient, and as such, should have been given oxygen, attached to a heart monitor, and continuously observed. It is also undisputed that, for a minimum of 10 minutes, Ms. Gordon was left unattended. After reviewing the entire record, we conclude that it was a longer period of time; nonetheless, leaving her unattended for the shorter period of time was still a breach of the standard of

care. The risk assumed by leaving Ms. Gordon unattended was that her heart would begin to beat irregularly and no one would be alerted, thereby making timely treatment impossible. We are not persuaded by Willis Knighton's contention that [Ms. Gordon's son]'s cries for help sufficiently alerted the staff. Assuming Ms. Gordon was attached to a monitor, [the son] was not trained to interpret the printout and could not know his mother was deteriorating until she lost consciousness. Furthermore, when an emergency room heart monitor sounds, time is not lost by nurses having to inquire which patient is in trouble. When Dr. Reed entered Ms. Gordon's room, she was suffering from an irregular heartbeat, which might have been avoided had she been given oxygen, and the irregularity almost certainly would have been detected and treated sooner if she had been properly monitored."[65]

While delays in treatment and inadequate patient monitoring remain the most common sources of triage liability, hospitals have incurred liability as well for inducing patients to leave the ED prior to treatment when it was unsafe to do so.

In *South Fulton Medical Center v. Poe*, for example, the plaintiffs brought their newborn to the defendant hospital's ED after the infant became cyanotic at home.[66] At triage, the infant's father demanded immediate attention by a physician, but the nurse refused to comply, noting that the infant's vital signs "were not alarming" and that the infant "slept through the examination."[67] A heated debate broke out between the father and the triage nurse, which ended with the nurse assuring the plaintiffs that "the baby was fine right now." The nurse instructed the plaintiffs to sit in the waiting room, and told them that a doctor would see them shortly. Interpreting this to mean that they had overreacted, the plaintiffs left the hospital a few minutes later, and the infant died shortly thereafter.[68]

In the medical malpractice action that ensued, the trial court found for the plaintiffs and awarded them $1.85 million in damages. Finding that the requisite consensual relationship existed between the plaintiffs and the hospital, and that the assurances of the triage nurse motivated the plaintiffs to leave the ED without treatment, the Georgia Court of Appeals affirmed.[69]

At most hospitals, triage personnel play little, if any, role in the formal discharge of patients. Because triage nurses tend to control the flow of patients through the ED, however, they often influence the decisions of patients waiting for treatment to a significant degree. In essence, triage personnel wield the power to steer patients into treatment or away from it. Unfortunately, as the triage nurse in *South Fulton* discovered, the wrong choice of words or conduct in this setting can have disastrous legal consequences.

For similar reasons, hospitals also should refrain from performing telephone triage. ED personnel have a hard enough time triaging patients after examining them in person, but this task becomes even more difficult when the person conducting the triage must rely entirely on a verbal description of the patient's condition. Hospitals, therefore, should respond to telephone requests for medical advice by recommending examination in the ED and by placing follow-up calls to ensure that such patients actually receive all necessary care.[70]

Defenses to Allegations of Triage Negligence

To prevail in a medical malpractice action, the plaintiff first must prove the existence of a consensual professional relationship with the defendant.[71] A hospital can defend successfully against a triage-related lawsuit, then, by proving that such a relationship never existed. Alternatively, the hospital might show that the patient voluntarily terminated a previously established professional relationship, as the defendant hospital did in *Matthews v. DeKalb County Hospital Authority*.[72] There, a patient came to the defendant hospital's ED after experiencing a transient episode of chest pain. The triage nurse classified the patient's condition as "non-life threatening," and the patient waited more than four hours for treatment before finally announcing her intention to leave. The hospital's social services representative pleaded with the patient to stay, but she left the ED anyway, and died two days later.[73] In the medical malpractice action that followed, the Georgia Court of Appeals affirmed the trial court's grant of summary judgment in favor of the hospital, finding that by leaving the ED, the patient had voluntarily severed any causal relationship with the hospital's actions.[74]

Since the plaintiff also must prove that the defendant hospital breached the applicable duty of care, a hospital can prevail as well by demonstrating that it "used that degree of care or skill which is expected of a reasonably competent hospital in the same or similar circumstances."[75] Hospitals accused of improperly triaging patients have achieved this goal in the past by showing that they lacked the facilities

to render the required treatment.[76] A hospital might therefore argue that its ED personnel conducted the triage process appropriately, but that the volume of patients waiting for care made it impossible to treat all of them in a timely manner.[77]

A third method by which a hospital might defend against allegations of improper triage is to prove that the acts or omissions of the triage personnel did not proximately cause the patient's harm.[78] In *Jackson v. State of Louisiana*, for example, the plaintiff drove her husband to a nearby hospital after he experienced a seizure. A triage nurse examined the patient and instructed the couple to "wait their turn." When the nurse called the patient in from the waiting room two hours later, he climbed onto an examining table, suffered another seizure, and died. At autopsy, the seizures were found to have resulted from myocardial infarction. The plaintiff brought a medical malpractice action against the hospital, and at trial presented an expert witness who testified that an "IV and other blood work" should have been started within 15 minutes of arrival at the hospital. The plaintiff's expert admitted, however, that these procedures would not have prevented the patient from suffering another heart attack or seizure. Finding that the delay in care had not caused the patient's death, the trial court entered judgment in favor of the hospital, and the Louisiana Court of Appeal affirmed.[79]

The New Jersey Superior Court reached an identical conclusion in *Greene v. Memorial Hospital of Burlington County*.[80] There, a mother brought her 10-year-old daughter to the defendant hospital's ED after the child complained of chest pains and lethargy.[81] The triage nurse noted that the patient was breathing shallowly, but nevertheless directed the pair to a waiting area. The child's condition deteriorated steadily, and by the time a different triage nurse called the patient back to the triage booth nearly two hours later, the child's heart rate had increased to 170 beats per minute and her respiratory rate had increased to 80 breaths per minute.[82] The triage nurse concluded from these vital signs that the child was hyperventilating, and instructed the patient to "relax and count her breaths in order to slow her breathing." To make matters worse, a physician who had not yet examined the child authorized the nurse to have the patient breathe into a paper bag.[83] The child soon seized, went into cardiac arrest, and died of pulmonary edema secondary to viral myocarditis.[84] The child's mother brought actions for medical malpractice and negligent infliction of emotional distress against the hospital, three nurses, a physician, and the professional association that provided ED services to the hospital. After settling with the hospital and its nurses, the plaintiff proceeded to trial against the remaining defendants.[85] The trial court refused to submit the issue of proximate cause to the jury, and instead granted the defendants' motion for judgment at the conclusion of the plaintiff's case.[86] The appeals court affirmed on grounds that the plaintiff had failed to produce evidence the defendants' negligence increased the risk of harm from the patient's preexisting myocarditis,[87] and that the plaintiff's grief represented a normal response to the death of a loved one.[88]

Those who seek to defend hospitals against claims of triage-related malpractice should bear in mind as well that the defendant hospital might enjoy some form of statutory immunity. While the doctrine of charitable immunity has all but disappeared from American law,[89] the Federal Tort Claims Act[90] and its state counterparts[91] limit the liability of government-operated facilities such as Veterans Administration and county hospitals. A specialty hospital that normally does not engage in the provision of emergency treatment may enjoy statutory immunity as well from so-called "Good Samaritan" statutes.

Liability under EMTALA

Responding to concerns that hospitals routinely transferred or turned away emergency patients for lack of insurance or ability to pay, Congress in 1986 passed EMTALA, otherwise known as the "Patient Dumping Act."[92] Intended as a supplement to state tort actions,[93] EMTALA incorporates neither a negligence nor medical malpractice standard in determining liability.[94] Rather, this act imposes strict liability on hospitals that violate its requirements.[95] Anyone who suffers "personal harm as a direct result" of such a violation may recover damages against the hospital.[96] A medical facility that sustains financial harm as a result of an EMTALA violation may recover damages as well.[97] EMTALA provides for civil monetary penalties, not only against hospitals that violate the Act,[98] but also against physicians responsible for those violations.[99]

EMTALA applies to all hospitals that receive federal Medicare funding and operate EDs.[100] A hospital covered by EMTALA must provide, within the capabilities of its ED, an "appropriate medical screening

examination" to every person requesting one.[101] To be "appropriate" under EMTALA, the screening examination need not satisfy traditional professional standards. Rather, the courts generally have required only that the hospital treat all patients—both paying and nonpaying—alike.[102] Furthermore, if the hospital finds that an emergency medical condition exists, or that the patient is in labor, the hospital must provide treatment to stabilize the patient's condition.[103] When the hospital cannot adequately care for the patient, it must provide transfer to a more appropriate facility.[104] A cause of action may arise under EMTALA in two ways, then. First, a hospital may incur liability in failing to provide the required screening examination,[105] and second, the claimant may show that the hospital became aware of a medical emergency as a result of the screening examination, but failed to stabilize the patient or provide the necessary transfer.[106]

Since triage personnel normally serve as gatekeepers for the ED, EMTALA violations sometimes arise as a result of triage decisions. A Louisiana Court of Appeal case, *Clark v. Baton Rouge General Medical Center*, demonstrates how an inappropriate triage decision may lead to a violation of EMTALA's screening requirement.[107]

Case #3

Clark v. Baton Rouge General Medical Center [108]

On May 13, 1989, named Rosemary Roubique arrived by ambulance to the ED of Opelousis (LA) General Hospital after suffering a massive stroke.[109] At the request of the patient's family, the hospital staff contacted Ms. Roubique's cardiologist, who ordered transfer to the defendant hospital, Baton Rouge General. At Baton Rouge, ED nurses performed elements of triage, including analysis of vital signs, but a receptionist advised the patient's family that Ms. Roubique could not receive treatment there because her insurance carrier had designated yet another facility, Our Lady of the Lake Hospital, as her primary health care provider.[110] Ms. Roubique's relatives responded that they would assume responsibility for expenses associated with emergency care, and refused to allow another transfer.[111]

While the various parties debated the insurance issue, the ED staff attached Ms. Roubique to a cardiac monitor and placed her in a bed directly across from the ED nurses' station. A nurse contacted the cardiologist who had ordered the original transfer, but the doctor declined to resolve the matter, stating that he was "no longer on call." The nurse reported Ms. Roubique's condition to another doctor by telephone, and this doctor ordered an electrocardiogram, chest X-ray, and blood work, as well as cardiology and neurology consultations, but did not actually come to the ED to examine the patient.[112]

For more than two hours, Ms. Roubique remained in a state of ED limbo. The hospital staff allowed her to occupy a bed, yet she received no care other than cardiac monitoring. At one point Ms. Roubique began to vomit. She attempted to pull the oxygen mask away from her face, but her daughters, who had not noticed the vomiting and misunderstood their mother's intentions, held the vomit-filled mask against her face and pressed the nurses' call button. Receiving no response, they ran into the hallway, pleading for assistance, but the nurses refused to touch Ms. Roubique, telling the patient's family that her insurance did not cover treatment at Baton Rouge General.[113] Instead, a member of the ED staff deposited bed linen at Ms. Rubique's feet and walked away, leaving the patient to lie in her own vomit.[114]

Eventually a neurologist elicited a "very abbreviated" medical history from Ms. Roubique's family. After a brief neurological examination, he concluded that Ms. Roubique's condition was stable enough for transfer, and an ambulance carried her to Our Lady of the Lake Hospital.[115] There she developed arrhythmias, progressive respiratory compromise, and another stroke that led to her death.[116]

Ms. Roubique's children and surviving spouse brought suit in Louisiana State Court.[117] A jury found that Baton Rouge General had breached EMTALA by failing to provide the required emergency medical screening,[118] but that it had not failed to stabilize Ms. Roubique's condition before transferring her to our Lady of the Lake Hospital.[119] The jury also found that while the hospital breached the standard of care owed to Ms. Roubique, that breach did not proximately cause her death. In calculating damages, the jury assigned 25% liability to the hospital and 75% liability to a pair of treating physicians not named in the suit. The jury awarded damages to Ms. Roubique's estate in the amount of $10,000 for physical pain, suffering, and mental anguish. In addition, the jury awarded damages of $20,000 to Ms. Roubique's spouse and each of her children for mental anguish and loss of companionship, love, and affection, and an additional $364 for medical expenses.[120]

On appeal, Baton Rouge General argued that Ms. Roubique's relatives never requested a medical screening on her behalf.[121] The hospital also claimed that EMTALA did not apply, since Ms. Roubique arrived at Baton Rouge General suffering from no "emergency condition." And finally, the hospital contended that Ms. Roubique had come to Baton Rouge General only at the direction of her cardiologist, and therefore did not "present herself" to the hospital so as to trigger the duty of an appropriate medical screening as required by the statute.[122]

The Louisiana Court of Appeal disagreed. Finding that Ms. Roubique had come to Baton Rouge General in critical condition, and without previous examination by her cardiologist, the court held that Ms. Roubique was entitled to an emergency medical screening under EMTALA.[123] The court also noted that in refusing to treat Ms. Roubique, Baton Rouge General had deviated from its own ED policy, which mandated the provision of a "medical evaluation" to every person requesting one.[124] The appeals court therefore held that the evidence supported the jury's determination that Baton Rouge General had failed to provide an appropriate medical screening as required by EMTALA.[125] The plaintiffs challenged the jury's finding as to the stabilization issue, but in light of overwhelming expert medical testimony that Baton Rouge General had transferred Ms. Roubique properly, the appeals court affirmed this portion of the verdict as well.[126]

Here, the defendant hospital had the opportunity to avoid EMTALA liability through a very simple action. Like the patient in *Gordon*, Ms. Roubique found herself triaged into the ED's version of a dead-end street. Rather than using the triage process to guide Ms. Roubique to the most appropriate type of care, the triage nurse at Baton Rouge General completed a perfunctory examination and thereafter left the patient unattended until a transfer could be arranged. Since the jury later found Ms. Roubique's condition stable enough for transfer, the hospital could have escaped EMTALA liability entirely had the nursing staff simply arranged for a more comprehensive initial examination.

Defending Against Triage-Related Claims

Unlike medical malpractice claims, which are based almost exclusively on common law principles, EMTALA claims derive from a single federal statute. One who endeavors to represent a hospital against such a claim must begin with a thorough knowledge of EMTALA's requirements.

To prevail in an EMTALA claim, the plaintiff must demonstrate that the defendant hospital: 1) failed to provide an appropriate screening examination,[127] or 2) failed to transfer a patient who presented with an emergency condition or in labor.[128] Whether such a violation has occurred is a question of fact.[129] A defendant hospital may defeat an EMTALA screening-examination claim, then, by showing that triage personnel did, in fact, perform an appropriate examination.[130] To qualify as "appropriate," such an examination need not be sufficiently comprehensive to defeat a malpractice claim.[131] Instead, most courts have held that a screening examination is "appropriate" for EMTALA purposes so long as the hospital examines paying patients in the same manner as nonpaying patients.[132]

Plaintiffs commonly attempt to show disparate treatment by producing evidence that the hospital departed from an established screening policy.[133] At times, the defendant can respond to such allegations by showing that the actions of the triage personnel really did conform to such a policy. If the hospital cannot produce such evidence, it may instead argue, as did the Amarillo Hospital District in *Casey v. Amarillo Hospital District*, that the policy violation did not cause the patient to be treated differently than any other patient.[134] In *Casey*, the plaintiffs contended that a triage nurse's failure to take a complete set of vital signs on a septic child, as required by hospital policy, constituted a violation of EMTALA's screening examination requirement. The hospital successfully countered this allegation with expert testimony that the child "received the same initial screening examination as any other patient would who presented with the same complaints and symptoms," notwithstanding the nurse's failure to obtain a blood pressure at triage.[135] In defending a hospital against an EMTALA claim, one should remember, as the New Mexico Court of Appeals noted in *Godwin v. Memorial Medical Ctr.*, that "[d]e minimus deviations cannot support liability for disparate treatment under the Emergency Act."[136]

Other plaintiffs attempt to demonstrate disparate treatment by focusing on motive. Some courts have interpreted EMTALA as requiring a showing by the plaintiff that the defendant's decision to transfer or discharge a patient was motivated by lack of insurance or other financial considerations.[137] As the

Texas Court of Appeals observed in *Casey*, however, the express language of the statute "provides in clear and unambiguous language that 'any individual' coming to an emergency room must be afforded an appropriate medical screening examination."[138] This language has led every federal appellate court that has considered the issue, with the exception of the Sixth Circuit in *Cleland v. Bronson Health Care Group*, to conclude that a plaintiff may state a cause of action under EMTALA even in the absence of such a showing.[139] Furthermore, the United States Supreme Court held in 1999 that plaintiffs need not establish motivation of any kind to prove that a hospital violated EMTALA's stabilization requirement.[140] In defending against EMTALA claims, then, hospitals should not expect to prevail simply because the plaintiff cannot prove improper motive on the part of the defendant.

A patient has the right to refuse a screening examination, thereby providing a defense against claims of violation. This is referred to as a voluntary withdrawal, as provided by Section 1395dd(b)(2) of the Act expressly requires four conditions in the case of refusals.[141] First, the hospital must offer to provide a screening examination and emergency treatment.[142] Second, the hospital must inform the patient of all risks and benefits associated with such services.[143] Third, the patient must decline the hospital's offer of examination or care,[144] or must request transfer to another facility in writing while knowing of the hospital's obligation to provide treatment.[145] And fourth, the hospital must take all reasonable steps to obtain the patient's written, informed refusal of consent.[146] A hospital, therefore, may escape EMTALA liability by showing that it performed these acts. Because the courts generally view EMTALA as imparting strict liability, however,[147] the burden in most cases falls on the defendant hospital to show that the patient voluntarily withdrew a request for treatment.[148]

A similar built-in defense exists with regard to EMTALA's *stabilization* requirement. Section 1395dd(b)(3) allows a hospital to forgo the transfer of an emergency patient who refuses to consent to such action. As with the provision that permits hospitals to forgo examination and treatment of reluctant patients, this section of the Act requires the hospital to inform the patient of associated risks and benefits, and to secure the patient's written statement of refusal when possible. Complying with these requirements will allow a defendant hospital to defeat a claim that it committed an improper transfer.

Some hospitals have found that personal interaction between an attending physician and patients facing delays in care helps to prevent the premature departure of seriously ill patients from the ED. By coming to the waiting room and discussing the risks of leaving, a physician gains the opportunity to explore the patient's complaint more thoroughly, to reassure waiting patients that they will eventually receive care, and to address complaints of inappropriate triage decisions. Studies in the prehospital arena have shown that reluctant patients are more likely to accept ambulance transportation to an ED following a radio or telephone conversation with an attending physician, so it makes sense to apply the same risk management strategy to patients in ED waiting rooms.

Conclusion

Triage, whether performed by a nurse, physician, or receptionist, creates a legal hazard for every hospital with an ED. Hospitals may incur liability for turning away patients prematurely, for inappropriately delaying treatment, and for failing to monitor patients waiting for care.

Hospitals can sidestep triage-related liability, however, by following relatively simple strategies. First, the hospital must ensure that qualified personnel perform this function. Hospitals have incurred civil liability for the negligent supervision of triage personnel,[149] and according to most authorities, this problem can best be avoided by utilizing experienced, specially trained registered nurses.[150] Hospital administrators should take special care to ensure that all ED personnel who perform triage receive training in the requirements of EMTALA.

Each hospital must develop clear and comprehensive triage policies. Administrators must supervise triage personnel to ensure that they comply with these policies. For the most part, hospitals should avoid telephone triage. Instead, triage personnel should recommend ED examination, and someone from the hospital should place a follow-up call to ensure that the patient receives adequate care.

Triage personnel should refrain from assuring patients that their conditions are not serious. To do so invites premature departure from the ED by critically ill patients. Patients must be triaged as quickly as possible, and ED personnel should strive to

keep waiting times short. Qualified personnel must monitor the condition of waiting patients at regular intervals, regardless of the patient's complaint. ED personnel must never delay treatment to obtain insurance information.

In all instances, the person responsible for triage must thoroughly document the patient's condition and treatment, from the moment the patient arrives in the ED until another qualified individual assumes responsibility for care. Such documentation will prove invaluable should the hospital face a triage-related malpractice or EMTALA claim.

Endnotes

1. *See Tailfeather v. Bd. of Supervisors of Los Angeles County*, 56 Cal. Rptr. 258, 258 (Cal. Ct. App. 1996).
2. *See generally* United States Department of Defense, *Emergency War Surgery* (1975).
3. *Id*.
4. Emergency Nurses Association, *Sheehy's Emergency Nursing* 105 (4th ed. 1998).
5. Emergency Nurses Association, *Position Statement: Role of the Emergency Nurse in Clinical Practice Settings*, 21 Journal of Emergency Nursing 24A (1995).
6. *Id*.
7. *See generally* Emergency Nurses Association, *Standards of Emergency Nursing Practice* (3d ed. 1995).
8. *See generally* Gail Handysides, *Triage in Emergency Practice* (1996).
9. *Feeney v. New England Medical Ctr., Inc*., 615 N.E.2d 585, 585 (Mass. App. Ct. 1993).
10. *E.g., Hunt v. Palm Springs Gen. Hosp., Inc*., 352 So.2d 582, 582 (Fla. Dist. Ct. App. 1977); Barcia v. Soc'y of New York Hosp., 241 N.Y.S.2d 373, 373 (N.Y. Sup. Ct. 1963).
11. *E.g., Chandler v. Hospital Auth. of the City of Huntsville, Alabama*, 548 So.2d 1384, 1384 (Ala. 1989).
12. *E.g., Owens v. Nacogdoches County Hosp. Dist*., 741 F. Supp. 1269, 1269 (E.D. Tex. 1990).
13. 42 U.S.C. § 1395dd (1999).
14. *E.g., Collins v. DePaul Hosp*., 963 F.2d 303, 303 (10th Cir. 1992); Gatewood v. Washington Healthcare Corp., 933 F.2d 1037, 1037 (D.C.Cir. 1991).
15. *E.g., Kilcop v. Adventist Health Care, Inc.*, 57 F.Supp.2d 925, 925 (N.D. Cal. 1999).
16. *Davis v. Johns Hopkins Hosp.*, 585 A.2d 841, 848 (Md. Ct. Spec. App. 1991); *Williams v. Hosp. Auth. of Hall County*, 168 S.E.2d 336, 337 (Ga. Ct. App. 1963); *Wilmington Gen. Hosp. v. Manlove*, 174 A.2d 135, 138-9 (Del. 1961); *Levin v. Sinai Hosp. of Baltimore*, 46 A.2d 298, 301 (Md. 1945).
17. *Id*.
18. *E.g*., N.Y. Pub. Health Law § 2805-b(1)(2001) (providing that "[e]very general hospital which maintains facilities for providing out-patient emergency medical care must provide such care to any person who, in the opinion of a physician, requires such care); 35 Pa. Cons. Stat. § 4449.8a (2001).
19. *E.g.,Thompson v. Sun City Community Hosp., Inc.*, 688 P.2d 605, 605 (Ariz. 1984); Guerrero v. Copper Queen, 537 P.2d 1329, 1329 (Ariz. 1975).
20. Chandler, 548 So.2d at 1387; *Birmingham Baptist Hosp. v. Crews*, 157 So. 224, 226 (Ala. 1934); *Citizens Hosp. Ass'n v. Schoulin*, 262 So.2d 303, 309 (Ala. Civ. App. 1972).
21. Hunt, 352 So.2d at 582. *See also* Methodist Hosp. v. Ball, 362 S.W.2d 475, 479 (Tenn. Ct. App. 1961).
22. 480 S.E.2d 40, 40 (Ga. Ct. App. 1996).
23. *South Fulton Medical Ctr. v. Poe*, 480 S.E.2d 40, 42 (Ga. Ct. App. 1996).
24. *Id.*
25. *Id.* at 44.
26. Hunt, 352 So.2d at 582.
27. 262 So.2d at 309.
28. Citizens Hospital Ass'n, 262 So.2d at 309.
29. *Id*. at 304-05.
30. *Id*. at 308.
31. *Id*. at 309.
32. Chandler, 548 So.2d at 1385.
33. *Id*.
34. *Id*.
35. *Id*.
36. *Id*.
37. *Id.*
38. *Id.* at 1387.
39. *Id*. at 1386.
40. *Id.* at 1387.
41. 615 N.E.2d 585, 585 (Mass. 1993).
42. Feeney, 615 N.E.2d at 586.
43. *Id*. at 587.
44. *Id*.
45. *Id*. at 586.
46. *Id*. at 588.
47. *Id*. at 585.
48. *Id*. at 587.
49. *Id*. at 587.
50. *Id*. at 587.
51. *Id*.
52. 661 So. 2d 991, 991 (La. Ct. App. 1995).
53. *Gordon v. Willis Knighton Medical Ctr*., 661 So.2d 991, 997.
54. *Id.* at 991.
55. *Id.* at 993.
56. *Id*.
57. *Id.* at 996.
58. *Id.* at 994.
59. *Id.* at 993.
60. *Id.* at 994.
61. *Id.* at 995.
62. *Id.* at 995-96.
63. *Id.* at 998.
64. *Id.* at 993.
65. *Id.* at 999.
66. South Fulton Medical Ctr., 480 S.E.2d at 42.
67. *Id.*
68. *Id.*
69. *Id* at 43-44.
70. *Shannon v. McNulty*, 718 A.2d 828, 828, (Pa. Super. Ct. 1998).
71. *Matthews v. DeKalb County Hosp. Auth*., 440 S.E.2d 743, 743 (Ga. App. Ct. 1994); Clough v. Lively, 387 S.E.2d 573, 573 (Ga. App. Ct. 1989).
72. Matthews, 440 S.E.2d at 743.
73. *Id.* at 744.
74. *Id.* at 745.
75. Davis, 585 A.2d at 841. *See also Jackson v. State of Louisiana*, 655 So.2d 795, 795 (La. Ct. App. 1995).
76. *See* Davis, 585 A.2d at 848. *See also Costa v. Regents of Univ.*

of California, 254 P.2d 85, 85 (Cal. Ct. App. 1953).
77. *See* Davis, 585 A.2d at 848-49.
78. *See Anthony v. Chembless*, 500 S.E.2d 402, 402 (Ga. Ct. App. 1998); Jackson, 655 So.2d at 797-98.
79. Jackson, 655 So.2d at 796-98.
80. 691 A.2d 369, 369 (N.J. Super. 1997).
81. *Greene v. Memorial Hosp. of Burlington County*, 691 A.2d 369, 371 (N.J. Super. 1997).
82. *Id*.
83. *Id*.
84. *Id.* at 372.
85. *Id*. at 371.
86. *Id.* at 373.
87. *Id.* at 374.
88. *Id.* at 375.
89. *See President and Directors of Georgetown College v. Hughes*, 130 F.2d 810, 810 (D.C. Cir. 1942); Bing v. Thunig, 143 N.E.2d 3, 3 (N.Y. 1957).
90. 28 U.S.C. § 2671-2680 (2001).
91. *See Montoya v. John Peter Smith Hosp*., 760 S.W.2d 361, 361 (Tex. Ct. App. 1988).
92. *Miller v. Medical Ctr. of Southwest Louisiana*, 22 F.3d 626, 628 (5th Cir. 1994); *Brooks v. Maryland Gen. Hosp., Inc.*, 996 F.2d 708, 710 (4th Cir. 1993).
93. *Hardy v. New York City Health & Hosps. Corp*., 164 F.3d 789, 792-93 (2d Cir. 1999); *Power v. Arlington Hosp. Ass'n*, 42 F.3d 851, 856 (4th Cir. 1994).
94. *Summers v. Baptist Medical Ctr. Arkadelphia*, 91 F.3d 1132, 1137 (8th Cir. 1996); *Baber v. Hosp. Corp. of America*, 977 F.2d 872, 880 (4th Cir. 1992).
95. *Repp v. Anadarko Mun. Hosp*., 43 F.3d 519, 522 n.5 (10th Cir. 1994) (quoting *Abercrombie v. Osteopathic Hosp. Founders Ass'n*, 950 F.2d 676, 681 (10th Cir. 1991)); *Hutchison v. Greater Southeast Community Hosp*., 793 F. Supp. 6, 8 (D. D.C. 1992). *But see* Summers, 91 F.3d at 1137 (characterizing EMTALA as "providing for strict liability in a sense").
96. 42 U.S.C. § 1395dd(d)(2)(A) (2001).
97. 42 U.S.C. § 1395dd(d)(2)(B) (2001).
98. 42 U.S.C. § 1395dd(d)(1)(A) (2001).
99. 42 U.S.C. § 1395dd(d)(1)(B) (2001).
100. 42 U.S.C. § 1395dd(e)(2) (2001); 42 U.S.C. § 1395cc (2001).
101. 42 U.S.C. § 1395dd(a) (2001).
102. *Marshall v. East Carroll Parish Hosp. Serv. Dist*., 134 F.3d 319, 322 (5th Cir. 1998); *Holcomb v. Monahan*, 30 F.3d 116, 117 (11th Cir. 1994); *Cleland v. Bronson Health Care Group*, 917 F.2d 266, 266 (6th Cir. 1990).
103. 42 U.S.C. § 1395dd(b)(1) (2001).
104. 42 U.S.C. § 1395dd(c)(1)(A)(ii) (2001).
105. *Casey v. Amarillo Hosp. Dist*., 947 S.W.2d 301, 301 (Tex. Ct. App. 1997).
106. *Id.*
107. 657 So.2d 741, 741 (La. Ct. App. 1995).
108. *Clark v. Baton Rouge Gen. Medical Ctr.*, 657 So.2d 741, 741 (La. Ct. App. 1995).
109. *Id.* at 743.
110. *Id.* at 743-44.
111. *Id.* at 744.
112. *Id.*
113. *Id.*
114. *Id.* at 746.
115. *Id.* at 744.
116. *Id*.
117. *Id.* at 743.
118. *Id.* at 744.
119. *Id.* at 747.
120. *Id.* at 744-45.
121. *Id.* at 746.
122. *Id.*
123. *Id*.
124. *Id*.
125. *Id*.
126. *Id.* at 747.
127. 42 U.S.C. § 1395dd(a) (2001).
128. 42 U.S.C. § 1395dd(b) (2001).
129. *Griffith v. Mt Carmel Medical Ctr.*, 831 F. Supp. 1532, 1543 (D. Kan. 1993); *Ruiz v. Kepler*, 832 F.Supp. 1444, 1446 (D. N.M. 1993); *Godwin v. Memorial Medical Ctr.*, No. 26, 919 (N.M. Ct. App. Apr. 5, 2001).
130. *E.g.*, Casey, 947 S.W.2d at 301.
131. *See* Baber, 977 F.2d at 872; Cleland, 917 F.2d at 266; *Deberry v. Sherman Hosp. Ass'n*, 769 F. Supp. 1030, 1030 (N.D. Ill. 1991).
132. Cleland, 917 F.2d at 266.
133. *E.g.*, Clark, 657 So.2d at 746; Casey, 947 S.W.2d at 305.
134. Casey, 947 S.W.2d at 305.
135. *Id*. at 305-06.
136. No. 26, 919. *See also* Repp, 43 F.3d at 523.
137. *See* Cleland, 917 F.2d at 266.
138. 947 S.W.2d at 305.
139. *See, e.g*., Power, 42 F.3d at 851; Summers, 91 F.3d at 1132; *Burditt v. U.S. Dept. of Health and Human Servs*., 934 F.2d 1362, 1363 (5th Cir. 1991); Gatewood, 933 F.2d at 1041.
140. *Roberts v. Galen of Virginia*, 525 U.S. 249, 249 (1999).
141. 42 U.S.C. §§ 1395dd(b)(2) (2001).
142. *Id.*
143. *Id.*
144. *Id.*
145. 42 U.S.C. § 1395dd(c)(1)(A)(i) (2001).
146. *Id.*
147. Repp, 43 F.3d at 522 n.5; Hutchison, 793 F. Supp. at 8.
148. *Stevison v. Enid Health Systems, Inc.*, 920 F.2d 710, 710 (10th Cir. 1990).
149. *Gray v. John R. Vaughn*, M.D., P.C., 460 S.E.2d 86 (Ga. Ct. App. 1995).
150. Emergency Nurses Association, *supra* note 5. *See also* Julie E. Bracken, *Triage*, in *Sheehy's Emergency Nursing* 105-11 (Emergency Nurses Association, ed.)(4th ed. 1998).

CE/CME Questions

1. Triage nurses should refrain from telling patients waiting for care that their conditions are not serious because:
   A. the patient may leave the emergency department prematurely.
   B. to do so would create a contract between the patient and the hospital.
   C. such statements often lead to disagreements between waiting patients.
   D. the patient might sue the nurse for defamation.

2. To avoid civil liability on the part of the hospital, triage nurses must do all of the following *except*:
   A. monitor the condition of waiting patients.
   B. triage patients by telephone.
   C. familiarize themselves with the requirements of the Emergency Medical Treatment and Active Labor Act.
   D. ensure continuity of prehospital care.

3. Under EMTALA, a hospital need not treat a patient who:
   A. arrives at the emergency department via private automobile.
   B. voluntarily withdraws his request for treatment after being informed of all relevant risks.
   C. has no medical insurance.
   D. suffers from a serious, but not life-threatening, condition.

4. To prevail against a hospital on a claim of triage-related malpractice, a patient must prove which of the following?
   A. That emergency department personnel directed him to sit in the waiting room for an extended period of time
   B. That he arrived at the emergency department with a life-threatening condition
   C. That emergency department personnel could have treated him sooner than they did
   D. That the hospital breached its duty to treat him, and that this breach was the proximate cause of his harm

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