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Supreme Court Turns Down EMTALA Case — Prompts CMS to Reconsider Applying EMTALA to Inpatients

Changes could markedly increase hospital liability related to inpatients and require hospitals with specialized capabilities to accept appropriate transfers of inpatients, not just ED patients.

By Robert A. Bitterman, MD, JD, FACEP, Contributing Editor
President, Bitterman Health Law Consulting Group, Inc.

The U.S. Supreme Court declined to review the controversial 6th Circuit decision in the case of ***Moses v. Providence Hospital***, where the federal appeals court rejected Centers for Medicare & Medicaid Services' (CMS) rule that EMTALA ends once a hospital admits a patient in good faith for further stabilizing care.[1]

In *Moses*, the issue was whether EMTALA applied to the discharge of a psychiatric patient from the hospital inpatient setting many days after he had been admitted through the emergency department (ED) for stabilizing care. After discharge, the patient went home and later murdered his wife, so the family sued Providence Hospital under EMTALA for failure to stabilize the patient prior to discharging him home. Under EMTALA, all discharges from the hospital are legally defined as "transfers," regardless of whether the discharge is from the ED or inpatient setting.[2] Thus, the plaintiff's claim was for "failure to stabilize the patient prior to transfer," as required by EMTALA.[3]

CMS

CMS, the government agency charged with interpreting EMTALA, had previously specifically addressed the issue of application of EMTALA to inpatients. It originally proposed to apply EMTALA to inpatients admitted through the ED until their emergency medical condition (EMC) was stabilized, but not to other inpatients or even to those admitted via the ED if they developed a "new" EMC sometime after the admitting emergency was stabilized.[4]

However, after a torrential condemnation from the medical community, and considering court opinions, particularly the reasoning of the 9th Circuit in the case of *Bryant v. Adventist Health System*,[5] CMS reversed its interpretation. In

September 2003, it published regulations holding that EMTALA ends when the patient is formally admitted to the hospital, if the admission is in good faith and not done to circumvent the hospital's obligations under the law.[6,7]

CMS noted that other patient safeguards protect patients once they are admitted to the hospital, such as the Medicare conditions of participation and state malpractice law.[7]

6th Circuit Court of Appeals[8]

The 6th Circuit in *Moses* rejected CMS' interpretation, and giving no deference to the agency's rulemaking authority, it overruled CMS' regulation that EMTALA ends when the hospital admits the patient in good faith.[6,9] The court determined that the rule was contrary to EMTALA's plain language, which requires a hospital to "provide ... for such further medical examination and such treatment as may be required to stabilize the medical condition."[10] Additionally, the court gave no credence to the myriad of other federal and state courts that had addressed the issue and affirmed CMS' view that EMTALA ends upon admission.[11,12]

Therefore, the 6th Circuit appellate court held that the hospital was required under EMTALA not just to admit the patient into an inpatient unit for further care, but actually to treat him such that he was stabilized before discharge.[3]

United States Solicitor General and the Supreme Court

The office of the U.S. Solicitor General (Elena Kagen; now Supreme Court Justice Kagen) filed a brief urging the Supreme Court to decline to accept the *Moses* case for review.[13] It noted that Congress expressly authorized CMS to promulgate rules and regulations interpreting and implementing EMTALA.[14] Furthermore, since Congress did not speak directly to this issue, expressly stating that EMTALA continues indefinitely after screening and stabilizing treatment in the ED, CMS' interpretation, while not the only permissible interpretation, was certainly a reasonable interpretation consistent with the statutory text, structure, purpose, and history of EMTALA. Accordingly, the appellate courts should have afforded deference to CMS on its regulations.[13]

The Solicitor General informed the court that CMS intended to reconsider its regulations related to the application of EMTALA to inpatients, and that it was committed to requesting comments from the public in 2010 and to proposing new rulemaking in 2011. Interpreting EMTALA to extend beyond the ED, as the 6th Circuit did, raised other questions not answered by Congress, questions which the Solicitor General felt would benefit greatly from CMS' expertise and experience, and from public comment during a rulemaking process, as CMS reconsidered how best to effectuate Congress' intent. For example, it noted that when CMS proposed in 2002 to extend EMTALA to inpatients, it did not propose to extend it to *all* inpatients.[13]

Curiously, the Solicitor General did not believe, as did the hospital appealing the case, that the 6th Circuit's decision would have "significant ramifications" for hospitals in the 6th Circuit (see below for a counter argument), even though it did think the 6th Circuit erred in holding that EMTALA's coverage unambiguously continued after an individual was admitted to the hospital in good faith.[13]

Once before, the Supreme Court refused to decide whether EMTALA applied to inpatients, stating that

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the issue had not yet been "sufficiently developed below [in the trial or appellate courts] for us to assess the argument."[15] With the 6th Circuit's decision in *Moses,* and a now clear split in the interpretation of the federal appellate courts, it sure seemed the issue was "sufficiently ripe" for the court to hear, but it demurred once again.

CMS to Reconsider if EMTALA Applies to Inpatients

In response to the *Moses* case and the Supreme Court's decision to refuse to hear the case on appeal, exactly as promised by the U.S. Solicitor General, in late 2010, CMS published an "advanced notice of proposed rulemaking" soliciting comments on whether it should rewrite two key rules on the application of EMTALA to hospital inpatients.[16]

Q1. First, should EMTALA apply to hospitals which admit patients for stabilizing care; and

Q2. Second, should hospitals with specialized capabilities be required to accept patients in transfer after they have been admitted at another hospital?

The second question was posed because in 2008, CMS issued a rule that hospitals with specialized capabilities did not have an EMTALA obligation to accept appropriate transfers of individuals who had been admitted in good faith as an inpatient at the first hospital.[17] Originally, similar to the first inpatient issue, CMS had proposed that these hospitals would be required to accept transfers of inpatients that the admitting hospital was unable to stabilize, assuming that the transfer of the individual was an appropriate transfer and that the accepting hospital had the capacity necessary to treat the individual.

After considering the comments it received, reviewing the EMTALA Technical Advisory Group recommendations, and weighing various pros and cons, CMS changed its mind yet again, and ultimately determined that specialized hospitals do not have an obligation under EMTALA to accept inpatients from other hospitals. In other words, because EMTALA ended for the hospital that admitted the patient, no other hospital had an EMTALA duty to accept the patient in transfer, even if the admitting hospital was not able to stabilize the patient.

The 6th Circuit's decision, if left to stand, or if it becomes the law of the land, would void CMS' regulation that hospitals are not required to accept inpatients in transfer. If EMTALA continues through admission until discharge, CMS loses its basis for claiming that hospitals do not have to accept inpatients with emergency conditions (EMCs) in transfer.[17,18]

Comments from the Medical Community on Question #1

Numerous hospital and physician organizations submitted comments to CMS. On CMS' first question, all uniformly and strongly beseeched CMS to retain its existing rule — that once a hospital admits a patient in good faith, the hospital has no further obligations under EMTALA — notwithstanding the 6th Circuit's ruling in the *Moses* case that the law's stabilization requirement applies to the discharge of inpatients, as well as the discharge of ED patients.[19]

Each reminded CMS that from a public policy perspective, there is no need for EMTALA to "protect" inpatients from being dumped by hospitals. First, all inpatient care is already subject to governance by a host of Medicare regulations, accreditation standards, and existing state-hospital licensure laws. (*See Table 1, which outlines the extensive list of statutory and regulatory protections already provided to inpatients by the federal government.*) Second, the act of admitting a patient establishes a doctor-patient relationship and hospital-patient relationship and, therefore, the hospital and admitting physicians have a legal duty to treat that patient according to the standard of care or they commit malpractice and/or legal abandonment, which are actionable under state law if the patient suffers any harm.

EMTALA's original purpose was to attach a duty that did not exist previously for hospital emergency departments. Pre-EMTALA, hospitals could deny emergency care or transfer (dump) patients from their EDs because there were no existing federal or state laws requiring them to examine, treat, or admit patients (at least in about half of the states). This allowed hospitals to avoid the attachment of state-law duties by refusing to treat or admit patients. Post-EMTALA, hospitals must medically screen/examine patients, and if an EMC is discovered, they must stabilize the patient before transfer. EMTALA obligates the hospital to treat the patient's emergency condition before transfer or discharge, and the primary way hospitals do that is by admitting the patient for care beyond the ED.

Additionally, CMS' requirement that the admission be in "good faith," and not a ruse to avoid liability under EMTALA, also serves to protect inpatients.

If CMS allows the law to be applied to inpatients (or to prolonged boarding of admitted patients in the emergency department), then EMTALA truly does become a federal malpractice act, which the courts have assiduously been trying to avoid. Significantly, it makes the *hospital* directly liable for the negligence

Table 1. Existing Medicare Conditions of Participation Protecting Hospital Inpatients

- A Responsible Physician for Each Patient. (42 CFR 482.12(c)(4))
- Physician On Duty or On Call at all times. (42 CFR 482.12(c)(3))
- RN Supervision & Availability 24/7 to evaluate the care of each patient and be immediately available, when needed, to provide bedside care to any patient. (42 CFR 482.23(b))
- Right to Care in a Safe Setting. (42 CFR 482.13(c)(2)).
- Governing Body Ensures Accountability of the medical staff to the governing body for the quality of care provided to patients. (42 CFR 482.12(a)(5))
- Medical Staff — Organized and Accountable to the governing body for the quality of care provided to patients. (42 CFR 482.22(b))
- Quality Assessment and Performance Improvement governing body, medical staff, and administrative officials are responsible and accountable for ensuring that clear expectations for safety are established and that adequate resources are allocated for reducing risk to patients. (QAPI) (42 CFR 482.21(e))
- Discharge Planning process applicable to all patients; identification at an early stage of hospitalization all patients who are likely to suffer adverse health consequences upon discharge if there is no adequate discharge planning; transfer or refer patients, along with necessary medical information, to appropriate facilities, agencies, or outpatient services, as needed, for follow-up or ancillary care. (42 CFR 482.43(a),(d))
- Agreements with another hospital are required of CAHs in rural health networks for patient referral and transfer, communications systems and the provision of emergency and nonemergency transportation between the CAH and the hospital. (42 CFR 485.616)

SOURCE

1. American Hospital Association letter to Donald M. Berwick, MD, MPP, Administrator, CMS, on the application of EMTALA to inpatients dated February 15, 2011.

of its physician staff. Plaintiffs will not even have to sue the physicians; they can sue the hospital directly under EMTALA for all damages resulting from the physician's negligent stabilization of the patient, contrary to the current law in most states in our country.

Furthermore, the hospital and admitting physicians, just like emergency physicians, would be subject to civil monetary penalties (CMPs) and termination from Medicare for negligently failing to stabilize the patient prior to discharge from the inpatient setting. Routing "premature discharge claims" for inpatients will now be EMTALA violations, and every family or plaintiff attorney concerned that "grandma was sent home too early" can trigger a 2-3 day investigation of the hospital under EMTALA, with its attendant costs of time, effort, public-relations stigma, and drain of monetary resources of hospitals already strained financially.

If EMTALA applies to inpatients, then CMS or the courts not only create a federal malpractice statute for "failure to stabilize," they strip the states of their sovereign ability to determine, for themselves, the balance necessary between tort remedies and tort protections to ensure the availability of access to care for its denizens. EMTALA preempts all state tort laws that conflict with it, including the state laws limiting liability, such as municipality immunity, charitable immunity, and state tort reforms, such as expert-witness requirements, discovery limitations, and statutes of limitation. In addition, some state and federal courts have held that a state's cap on noneconomic damages does not apply to EMTALA claims, contravening the intent of the state legislature.[20]

Note that EMTALA is already a federal malpractice act for emergency departments; every patient diagnosed with an EMC and treated and released from the ED is subject to a failure to stabilize claim under EMTALA. Thus, once the ED determines a patient has an EMC, the patient can sue the hospital under EMTALA for damages if the hospital negligently failed to stabilize the patient in the ED, either before transfer to another hospital or before discharge to home.

EMTALA was meant to prevent dumping, the transfer of unstable patients from one hospital to another because of economic reasons. It was not meant, nor is it needed, to govern the treatment of patients with EMCs in the hospital inpatient setting.

Comments from the Medical Community on Question #2

Whether hospitals with specialized capabilities

should be required under EMTALA's non-discrimination section to accept inpatients from other hospitals is much more controversial.[21]

Academic and tertiary hospitals vehemently oppose any more obligations to accept still more patients in transfer. They make a cogent argument that applying EMTALA obligations to inpatients will increase the pool of patients who could be transferred inappropriately or unnecessarily, which will further burden already overcrowded facilities and subject them to additional regulatory and civil liability.

However, EMTALA was passed to prevent hospitals from denying emergency care to the indigent. If a tertiary hospital refuses to accept an *inpatient* in transfer with an emergency condition that the transferring hospital can't stabilize, simply because the patient has no insurance, how is that any different? Why should it matter if the patient is in the ED or the inpatient setting? Remember, the transfer acceptance mandate was actually added long after EMTALA was originally passed. It was enacted precisely to prevent more capable hospitals from refusing to accept appropriate transfers for economic reasons, hence the title "non-discrimination section."

If EMTALA's non-discrimination section does not apply to inpatients, then we are, in essence, sanctioning economic discrimination against inpatients with EMCs. Now inpatients, instead of ED patients, are the class of persons discriminated against for economic reasons. Is it likely the federal courts will establish two different legal standards of emergency care depending upon whether the patient is an ED patient or an inpatient, and allow hospitals to, once again, legally deny emergency care to the uninsured?

Patients presently are at risk of death, just like before EMTALA was passed, because referral hospitals may refuse transfers of individuals with EMCs on account of their insurance status "because EMTALA ended upon admission."

The plain language of the non-discrimination section, though, does not condition the acceptance of such patients on their location in the transferring hospital, whether their EMC is stable or unstable at the time of transfer, whether they entered the hospital via the ED, or whether the law still applies to the transferring hospital at the time the transfer is medically necessary.[21] The application of EMTALA, and access to emergency medical care, shouldn't depend on which door patients entered the hospital through, or their admission "status" in their hour of need.

If the patient has an EMC, and the hospital is unable to treat that emergency condition, and it is medically indicated that the patient be acutely transferred to another hospital to treat the EMC, then EMTALA's non-discrimination section should require the receiving hospital to accept the patient in transfer whenever it is capable of treating the emergency.

Will Hospitals Accept Inpatient Transfers Absent an EMTALA Obligation?

CMS asked for comment on the accuracy of its statement in its 2008 final rule that *"a hospital with specialized capabilities would accept the transfer of an inpatient with an unstabilized EMC, absent an EMTALA obligation."*[16]

This is generally true of most hospitals most of the time, but it definitely is not routinely true. Many hospitals across the country, including tertiary and academic medical centers, large referral hospitals, and small community hospitals, have set up "transfer-acceptance systems" that are specifically designed to accept *only* those transfers that they are mandated to accept under EMTALA (and under state law, if their state has a law governing the acceptance of transfers).

Even if a hospital is willing to accept all patients in transfer, its medical staff certainly is not. Many physicians who take on-call duty at these hospitals do not want the burden of accepting transfers from outside facilities, especially uninsured patients, and particularly if they feel as if they are "being dumped upon" by outside communities. Therefore, the hospital fashions it transfer-acceptance system to only accept EMTALA-mandated transfers, and it then leaves the *option* of accepting or rejecting non-EMTALA-mandated transfers to the individual medical-staff members.

Another way to look at this issue is to understand that when the physicians are on-call, they represent the hospital, not their private practice and, as such, they must accept EMTALA-mandated transfers because the hospital has the legal duty to accept such transfers. However, if the transfer is not mandated by EMTALA, then the hospital has no legal duty to accept the patient, and the on-call physician can now operate in private practice mode and *choose* which patients to accept in transfer.

The Federation of American Hospital's (FAH) self-serving answer to the difficulty in accessing specialty care was, and I quote, "Congress should enact federal legislation requiring physicians to provide uncompensated on-call coverage as a condition of receiving Medicare payment," and also enact "legislation which mandates, or creates a strong incentive for, states to impose a requirement that physicians provide on-call services as a condition of their state licensure."[22] The FAH wants the government to

appropriate and nationalize physician services by forcing them to provide on-call services and uncompensated care. Unfortunately, imposed indentured servitude works only for so long before the service providers up and quit.

The American Hospital Association stated that hospitals should *not* be required to accept inpatients in transfer because "EMTALA was designed with a significant, and limited, objective — to assure that *all individuals* in need of emergency services have access to care."[23]

I suggest that statement is precisely why they *should be required* to accept transfers of patients with EMCs, and *all individuals* with EMCs includes inpatients as well as ED patients. ■

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10. 42 USC 1395dd(b)(1)(A).
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Source

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About to Date an ED Patient? Don't Ignore These Legal Risks

It's ammunition for plaintiff's counsel

Developing personal relationships with ED patients involves ethical, as well as possible legal implications, says **William Sullivan**, DO, JD, FACEP, director of emergency services at St. Margaret's Hospital in Spring Valley, IL, and a Frankfort, IL-based practicing attorney. "Some ethicists have questioned whether it is wise to merge one's social and professional lives," he adds.

Frank Peacock, MD, vice chief of emergency medicine at The Cleveland (OH) Clinic Foundation, says that if an emergency physician (EP) dates an individual after meeting him or her in the ED, "that's a real problem. Legally, you are allowed to date people, but it is high-risk behavior to try to contact a patient after an ED visit."

If you aren't caring for the patient and went into his or her chart to get a phone number, Peacock says, "there could be all sorts of legal action involving that scenario."

"The medical records are considered private material, and if you have no business in there, it's easily a [Health Insurance Portability and Accountability Act] HIPAA violation," says Peacock. "The patient wouldn't even have to be the one who brought the suit. If the hospital becomes aware that you have done that, it's a $50,000 fine for each violation."

Arthur R. Derse, MD, JD, FACEP, professor of bioethics and emergency medicine at the Medical College of Wisconsin in Milwaukee, says the best practice for EPs is to consider patients and former patients to be off limits for personal relationships.

Derse notes that a number of medical examining and licensing boards specifically state that having an inappropriate relationship with a patient violates their codes. "In some of these, a patient is defined as up until *two years* after medical care was provided," he says. "There is a large potential danger area."

While these codes are generally meant to apply to ongoing doctor-patient relationships, as in psychiatry, says Derse, "a savvy lawyer could use this in a malpractice lawsuit, as evidence that an emergency physician was acting inappropriately."

Evidence Against You

If you date an ED patient, says **John Burton**, MD, chair of the Department of Emergency Medicine at Carilion Clinic in Roanoke, VA, "the first place where you'd get into trouble is not necessarily legally, but with the state board of medicine."

Most complaints against physicians alleging an improper relationship with a patient ultimately end up at either the state board of medicine or the hospital ethics board, which often reports to the hospital executive board, notes Burton.

If a patient complains to the medical examining board, says Derse, this complaint might be used as evidence against you in a subsequent malpractice lawsuit.

If your behavior is sanctioned, warns Burton, this will be on your record and most likely would get reported out to the National Practitioner Data Bank. "These things are increasingly being investigated aggressively and reported out to boards, which have very little tolerance for these kind of activities," Burton says. "And if the board investigates it, you'd better get a lawyer because your whole career is on the line."

Jennifer Lawter, RN, JD, vice president of risk management at EPMG in Ann Arbor, MI, notes that most medical and nursing societies have guidelines and/or rules that they enforce when it comes to moral and ethical obligations of their members. "Physicians and nurses need to be concerned about these expectations, as well as the various state-licensing organizations, so that they do not run afoul of the requirements," she says.

Most insurance coverage for medical-malpractice litigation doesn't typically cover licensing investigations, adds Lawter, which can be costly. "You may find yourself with licensing-violation allegations, or perhaps be 'kicked out' of professional societies," she says.

"While this may not be as scary as a medical-malpractice lawsuit at first glance, it can lead to more problems than you may be prepared for," says Lawter. "These issues will nearly always show up in any future litigation."

Crossing the Line

Ann Robinson, MSN, RN, CEN, LNC, principle of Robinson Consulting, a Cambridge, MD-based legal-nurse consulting company, says that when you become involved with an ED patient, "you have crossed the line of an agreement. It's muddy water, at the very least."

If a patient sued the ED, and a jury learned that a nurse or physician had dated that patient, she says, "it would be very difficult for the hospital to defend itself. Its credibility would be undermined."

The social relationship with the patient, says Robinson, "would be ammunition for the plaintiff's counsel to prove the hospital was not looking out for the best interest of the patient."

Matthew Rice, MD, JD, FACEP, former senior vice president and chief medical officer at Northwest Emergency Physicians of TEAM Health in Federal Way, WA, says, "There are certain barriers you have to place between you and the patient, as a professional. When those barriers start to break down, huge problems occur."

Rice notes that Washington state has taken a serious stand on this issue, with its Medical Quality Assurance Commission recently establishing written boundaries on appropriate behavior. "Actions will

be taken against you as a professional if you cross over the boundaries we believe to be there," says Rice. "This is critical for those people who think they can be a physician and casually associate with their patients."

If an ED patient decides, at any point in time, to bring an action for medical malpractice, says Lawter, the nurse or physician named in the lawsuit would be at a significant disadvantage if a personal relationship existed.

"Much of this depends on when the relationship develops. Ideally, it should be much later, after the ED treatment has taken place," she adds. ■

Sources

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Relationship with Patient and Still Treating? Lawsuit Possible

It's "asking for trouble"

If an emergency physician (EP) continues to treat a patient *after* a social relationship has developed, he or she faces significant legal risks, according to **Jennifer Lawter**, RN, JD, vice president of risk management at EPMG in Ann Arbor, MI.

"It is much more difficult to be certain you are providing appropriate and objective care if you are treating someone with whom you have a social relationship," she explains. "You are leaving yourself open to inferences that you would not otherwise have to deal with in a litigation environment."

If you are dating an ED patient, and continue to treat the patient in some way, "you are now in a very difficult position," says **Arthur R. Derse**, MD, JD, FACEP, professor of bioethics and emergency medicine at the Medical College of Wisconsin.

If the EP refilled a prescription for narcotics for that former patient as a favor, the patient could later claim he or she became addicted to the medication as a result of the erosion of the boundary of the doctor-patient relationship, says Derse.

"Conversely, the patient may claim that you inadequately treated the patient's pain because of your relationship," says Derse. "There is a potential for legal action on both sides of that scenario."

In the case of an EP prescribing narcotics or other more significant forms of treatment to a person he or she is dating, Lawter says "that's just asking for trouble."

Lawter says that while many lawsuits have occurred with this scenario within other specialties, such as psychiatry, she is unaware of any that have involved EPs specifically. "This is probably because EPs do not normally have the types of ongoing relationships with patients that allow these types of problems to develop," she says.

The blurring of the doctor-patient relationship can become a legal issue, warns **John Burton**, MD, chair of the Department of Emergency Medicine at Carilion Clinic in Roanoke, VA, particularly if the EP is prescribing scheduled substances.

Many states now have laws requiring any physician caring for a patient to have a formal doctor-patient relationship and medical records, adds Burton. "If I'm dating you and I write you a prescription, then now I'm in trouble twice," he says. "We don't have a doctor-patient relationship, and there are no records."

If You 'Friend' ED Patient, Can Legal Problems Result?

When putting your identifying information onto a social network, says **William Sullivan**, DO, JD, FACEP, director of emergency services at St.

Margaret's Hospital in Spring Valley, IL, and a Frankfort, IL-based practicing attorney, remember that you can be found not only by friends, but by people you *don't* want to find you — including your ED patients. There are potential legal risks if an ED patient contacts you via social media, he warns.

Sullivan says that he joined Facebook to find out about high-school and college friends, until a patient posted a message on his "wall" to complain that he wouldn't prescribe her narcotic pain medications in the ED. "I immediately deleted my account," he says.

If patients post medical questions on your Facebook wall, says Sullivan, there is a question as to whether they have given you consent to discuss their medical care in this open forum.

"'Friending' a patient will allow the patient access to all your personal photos and to all your other friends," says Sullivan. "Is that something you want to happen?"

All Fair Game

If an EP "friends" a patient, says **Arthur R. Derse**, MD, JD, FACEP, professor of bioethics and emergency medicine at the Institute for Health and Society at the Medical College of Wisconsin, "the normal boundary in the patient relationship starts getting eroded." If that patient ends up suing the EP for malpractice, the attorney will be able to discover these postings, says Derse. "If the EP said something that seemed funny while chatting online, it may now seem flippant. Now, all of that is fair game for the attorney."

For instance, a comment on a patient's Facebook wall such as, "I told you it would probably turn out to be nothing!" can be used to demonstrate that the EP wasn't really taking the client's problem seriously, says Derse.

"The attorney could use that to set the stage for how the patient encounter went overall," he says. If a patient sends you a "friend" request, Derse recommends replying, "Sorry, I can't 'friend' patients or former patients."

It's All Discoverable

Increasingly, says **John Burton**, MD, chair of the Department of Emergency Medicine at Carilion Clinic in Roanoke, VA, organizations are taking stances against use of social-networking sites. "They are saying that physician employees should not be in any kind of relationship with patients, including on the Internet," he says. "A 'friend' request might start out as a very simple thing, but usually goes over the line to unethical behavior."

Recently, Burton was contacted by a waiter who served him at a restaurant, who found his contact information on the hospital website, and wanted help finding a psychiatrist.

"This was a potentially explosive situation," he says. "The person seemed to be stable in my limited interaction with him, and I'm also an empathetic person and wanted to help."

Burton sent the man some referral information, but it raised the issue of what he would have done if the request had been different. "What if he emailed that he needed a new lithium prescription?" asks Burton. "Do I help him with that? Of course not, but how do I respond?"

On-line communication, says Burton, is allowing patients to break down traditional barriers in contacting physicians. "You have to be very careful, because you can get into legal and certainly ethical areas on both sides," he says.

You likely feel an ethical responsibility to offer help as an EP if you see a motor-vehicle accident with obviously injured people, says Burton, while a patient's email request for help is not as clear-cut.

"You are clearly not legally obligated to provide a service to an individual who contacts you via social media," says Burton. "Remember that this is all discoverable in the event of a lawsuit."

Be Proactive

Jennifer Lawter, RN, JD, vice president of risk management at EPMG in Ann Arbor, MI, says that many hospitals around the country have developed no-tolerance policies with respect to social networking. "Nurses and physicians have been fired for discussing patients on Facebook, even when names were not mentioned," she says.

In November 2010, the American Medical Association issued a policy on professionalism in the use of social media, including a recommendation that physicians should separate personal from professional information. "These will likely be used against physicians in lawsuits if they do not comply," Lawter says. "They specifically mention that, as a general rule, physicians should not accept 'friend' requests from patients, especially if your only relationship with them, at that point, is as a patient."

Lawter says that while she's unaware of any litigation directly on-point with the above issues, "perhaps, given more time and opportunity, it will develop. I think this is a ripe opportunity for emergency physicians and nurses to be proactive." ■

Discrepancies in Readings of ED X-rays Pose Risks

Patients can be harmed

After the emergency physician's (EP) preliminary reading of a seizure patient's X-ray was negative, the patient was discharged, but the following day, the radiologist's report showed compression of the spine.

"The results weren't conveyed to the EP who had ordered the test," says **Denise Martindell**, RN, JD, a patient safety analyst at ECRI Institute under contract for the Pennsylvania Patient Safety Authority based in Harrisburg, PA, which collects data on near-misses. "This would have resulted in a potential delay in diagnosis." In this case, the patient came back to the ED several days later and was admitted for neurosurgical intervention, says Martindell.

About one-third of the discrepancies between an EP's opinion of an X-ray and the final opinion from a radiologist involved a potentially significant clinical finding, such as a fracture, pneumonia, or appendicitis, according to an analysis of 195 reports submitted in 2008 to the Pennsylvania Patient Safety Authority.[1]

Patients may be harmed if a discrepancy is *not* appropriately communicated between the radiology department and ED, warns Martindell, the Advisory's author.

"A process must be in place for radiologists to communicate such discrepancies in a timely manner to EPs," she says. "This ensures patients will receive appropriate follow-up care."

Communication was a factor in 28% of the discrepancies, with significant clinical findings that weren't followed up on, according to Authority reports. "We so often find that communication between providers is a contributing factor to adverse events," says Martindell. "We do find that consistently." She recommends standardizing communication between radiology and the ED, as a risk-reduction strategy.

The ED's system for this may vary, notes Martindell, depending on factors such as availability of an electronic medical record. Regardless, she says that policies and procedures must be applied consistently across shifts.

"It doesn't matter what type of technology you have. Some facilities have electronic transfer of X-rays to radiology, and some don't," says Martindell. "It really is incumbent on the ED to have a process to consistently make that happen."

Breakdowns Can Occur

Martindell says that communication breakdowns can occur in "the first link in the chain" when the ED is transmitting the report for interpretation to radiology, or the next step, when the radiologist's interpretation comes back to the ED.

Potential liability exposures for EDs for either of these scenarios include potential delay in diagnosis, failure to diagnose, and misdiagnosis, she says.

"We have seen reports of the radiologist's report not being timely, or the ED not receiving it at all," she says. "The reasons for that would vary by the institution, but the ED generated the X-ray. So it is incumbent on the ED to make sure it's acted upon."

The ED must have a process for reconciling the radiologist's final interpretation with the care the patient received, advises Martindell. Any verbal communication between the ED and radiology should be documented, she adds.

"The other piece where the system can break down is from the ED to the subsequent treating provider," says Martindell. "This is the last step in the communication chain. Each step in this chain is as important as the next."

When the EP sees the radiologist's interpretation, he or she must reconcile this with the patient's medical record, Martindell explains. Since the patient probably will have been discharged already, she says, there has to be a system for notifying the subsequent treatment physician or the patient.

Potentially successful approaches include having the ED physician, a designated nurse, or other individual do this, says Martindell. "Different EDs have different ways of doing this," she says. "It is important to document the attempts to reach the patient. The process should include the subsequent treating physicians. Contact with subsequent providers is very important." ■

REFERENCE

1. Matindell D. Communication of radiographic discrepancies between radiology and emergency departments. *Pa Patient Saf Advis* 2010; 7(1):18-22.

Source

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Tempted to "Cover Yourself?" It May Backfire

If you have a conflict with a colleague, do you document only facts and objective observations — or accusatory statements such as, "Despite my intervention, the doctor refused to acknowledge what I am telling him?"

Rade B. Vukmir, MD, JD, FACEP, chief clinical officer of the National Guardian Risk Retention Group and chairman of education at Emergency Consultants, Inc, both based in Traverse City, MI, and adjunct professor of emergency medicine at the Temple University School of Medicine Clinical Campus in Pittsburgh, says that he thinks most practicing EPs realizes that conflicts in the chart are disadvantageous to everyone, including the patient.

"On the other hand, that doesn't seem to restrict some practitioners from being involved in that sort of back and forth," says Vukmir.

Avoid pointing out allegedly poor decision-making by other nurses or physicians, says **Randy Pilgrim**, MD, FACEP, chief medical officer for the Schumacher Group in Lafayette, LA. "An attempt to cover your own liability at the expense of another often backfires on everyone," he warns.

Keep Complaint Separate

When disagreements with others occur, "warfare and blaming on the chart is an absolute no-no," says **Hartmut Gross**, MD, a professor of emergency medicine at Medical College of Georgia in Augusta. "You may think this is protecting you, but it will likely put you into more legal trouble."

If you are angry or frustrated, Gross advises waiting a few minutes before you put pen to paper and write something you will regret later. "Even if there isn't a bad outcome to the patient, will you feel your note is professional when you get called in to discuss the case before a peer review panel?" he asks.

Bear in mind that some things should *not* be documented in the chart, says Gross. "If the consultant is rude and condescending, sure, you're mad. But that interaction has no place in the medical record," he advises. "File that complaint separately."

On one occasion, Gross had to raise his voice to ask a consultant to leave a patient's room, as he was verbally badgering a patient. He left as Gross was calling security to have him removed.

"I apologized to and calmed the patient, and then called a different consultant to admit the patient," says Gross. "I put a scant oblique note in the chart noting that there was an occurrence, and filed a separate formal complaint describing the details of the event with the department chairman."

More Risk for You

Suppose that you call a medical staff member about a patient who clearly meets criteria for admission, and you get not only a rude response, but also an outright refusal to come in to evaluate the patient.

In this situation, says Pilgrim, EPs may be tempted to document something like: "The medical staff physician is unaware of appropriate admission criteria, and even refuses to evaluate the patient despite my repeated requests. I have no alternative other than to discharge the patient home, despite my better judgment."

The EP may believe this is covering his or her own liability, says Pilgrim, but "unfortunately, this can act as a lightning rod for a plaintiff's attorney. In addition to highlighting a potential problem with patient care, it reflects poorly on the EP also. It can bring unintended focus and increased risk for you." ■

Sources

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CNE/CME OBJECTIVES

After completing this activity, participants will be able to:

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

CNE/CME QUESTIONS

14. Which is true regarding an emergency physician's (EP) personal relationship with an ED patient, according to **Jennifer Lawter**, RN, JD, vice president of risk management at EPMG in Ann Arbor, MI?
    A. If a patient complains to the medical examining board, this cannot be used as evidence against the EP in a subsequent malpractice lawsuit.
    B. Allegations of licensing violations *cannot* be brought up during future litigation.
    C. Insurance coverage for medical malpractice litigation always covers licensing investigations.
    D. If an ED patient decides at any point in time to bring an action for medical malpractice, the nurse or physician named in the lawsuit would be at a significant disadvantage if a personal relationship existed.

15. Which is *true* regarding liability risks involving discrepancies between an EP's opinion of an X-ray and the final opinion from a radiologist, according to **Denise Martindell**, RN, JD, a patient safety analyst at the Pennsylvania Patient Safety Authority?
    A. Attempts to reach the patient or the subsequent treating physician should be documented.
    B. Standardized communication between radiology and the EP has been found to increase legal risks.
    C. The EP cannot be held liable for communication breakdowns that resulted because the hospital was unable to electronically transfer X-rays to radiology.
    D. The EP cannot be held legally responsible for failing to notify the subsequent treating physician or the patient about a discrepancy if the patient was already discharged.

16. Which is recommended regarding documentation in the chart, in the event of a conflict between care providers, according to **Hartmut Gross**, MD, a professor of emergency medicine at Medical College of Georgia in Augusta?
    A. EPs should not hesitate to chart accusatory statements.
    B. EPs should always document poor decision-making by other nurses or physicians.
    C. A consultant's condescending behavior should always be documented.
    D. If a consultant is rude, this should be filed as a separate complaint and not documented in the medical record.

CNE/CME INSTRUCTIONS

Physicians and nurses participate in this CNE/CME program by reading the issue, using the references for research, and studying the questions. Participants should select what they believe to be the correct answers, then refer to the answer key to test their knowledge. To clarify confusion on any questions answered incorrectly, consult the source material. After completing the semester's activity, you must complete the evaluation form provided and return it in the reply envelope to receive a letter of credit. When your evaluation is received, a letter of credit will be mailed to you. ■

Answers: 14. D; 15. A; 16. D

ED Legal Letter

Reader Survey 2011

In an effort to ensure *ED Legal Letter* is addressing the issues most important to you, we ask that you take a few minutes to complete and return this survey. The results will be used to ensure you are getting the information most important to you.

Instructions: Mark your answers by filling in the appropriate bubbles. Please write in your answers to the open-ended questions in the space provided. Return the questionnaire in the enclosed postage-paid envelope. The deadline is **July 1, 2011**.

Questions 1-12 ask about coverage of various topics in *ED Legal Letter*. Please mark your answers in the following manner:

	A. very useful	B. fairly useful	C. not very useful	D. not at all useful
1. ED handoffs (June 2010)	O A	O B	O C	O D
2. State medical malpractice wars, part 1 (July 2010)	O A	O B	O C	O D
3. State medical malpractice wars, part 2 (Aug. 2010)	O A	O B	O C	O D
4. Impaired health care practitioners (Sept. 2010)	O A	O B	O C	O D
5. Policies and guidelines (Oct. 2010)	O A	O B	O C	O D
6. Medical malpractice and risk management, part I of II (Nov. 2010)	O A	O B	O C	O D
7. Medical malpractice and risk management II (Dec. 2010)	O A	O B	O C	O D
8. Liability in ordering and prescribing meds (Jan. 2011)	O A	O B	O C	O D
9. Failure to follow own policies (Feb. 2011)	O A	O B	O C	O D
10. Online postings in malpractice trial (March 2011)	O A	O B	O C	O D
11. Managing acetaminophen toxicity (April 2011)	O A	O B	O C	O D
12. Supreme Court rules on EMTALA case (May 2011)	O A	O B	O C	O D

13. How would you rate your overall satisfaction with your job?

O A. very satisfied O B. somewhat satisfied O C. somewhat dissatisfied O D. very dissatisfied

14. Are the articles in *ED Legal Letter* written about issues of importance and concern to you?

O A. always O B. most of the time O C. some of the time O D. rarely O E. never

Please rate your level of satisfaction with the items listed. Please mark your answers in the following manner:

	A. excellent	B. good	C. fair	D. poor
15. quality of newsletter	O A	O B	O C	O D
16. article selections	O A	O B	O C	O D
17. timeliness	O A	O B	O C	O D
18. length of newsletter	O A	O B	O C	O D
19. overall value	O A	O B	O C	O D
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O A. fewer than 100 beds O B. 100-200 beds O C. 201-300 beds O D. 301-500 beds O E. more than 500 beds

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O A. fewer than 30 minutes O B. 30-59 minutes O C. 1-2 hours O D. more than 2 hours

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If no, why not? _____

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26. To what other publications or information sources do you subscribe? _____

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27. Which publication or information source do you find most useful? _____

_____

28. What do you like most about that publication or information source? _____

_____

29. What is your title?

O A. Emergency medicine physician O B. Department administrator O C. Nurse
O D. Risk manager O E. Other (please specify) _____

30. List the top three challenges you face in your job today. _____

_____

_____

31. What do you like most about *ED Legal Letter*? _____

_____

_____

32. What do you like least about *ED Legal Letter*? _____

_____

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33. What specific topics would you like to see addressed in *ED Legal Letter*? _____

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Contact information (optional): _____

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