ED Legal Letter™

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The Essential Monthly Guide to Emergency Medicine Malpractice Prevention and Risk Management

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Correction: In the June 2011 issue of *ED Legal Letter*, the cover article, "Legal Issues Surrounding the Critically Ill Patient in the ED" listed Justin A. Eisenman, DO, MS as the only author. The article was co-authored by Gregory P. Moore, MD, JD, Attending Physician, Emergency Medicine Residency, Madigan Army Medical Center, Tacoma, WA. We apologize for the error.

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Jury Awards Woman $200,000 After Hospital ED Sends Her Home to Deliver Her Dead 16-Week-Old Fetus

Court opinion and jury verdict create confusion and apprehension among emergency physicians regarding when EMTALA applies to pregnant women who are "having contractions" or who may be in "labor."

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

After a controversial court opinion and a highly charged emotional trial, a federal jury in Maine awarded Lorraine Morin $50,000 in compensatory damages and $150,000 in punitive damages against Eastern Maine Medical Center (EMMC) for failure to stabilize her prior to discharging her from the emergency department (ED) after a second-trimester miscarriage.

Facts of the Case — *Morin v. Eastern Maine Medical Center*[1]

Ms. Morin was 16 weeks pregnant when she presented to the ED at EMMC at 4:30 a.m. with abdominal cramping but no vaginal bleeding. Her past history included two live births, one miscarriage, post-partum depression, and cervical cancer with cone biopsy. The emergency physician (EP) examined her, obtained an ultrasound, which revealed no fetal movement or cardiac activity, and consulted the on-call obstetrician.

The obstetrician examined Ms. Morin at 5:25 a.m., noting "lower abdominal pain and discomfort like Braxton-Hicks contractions," no leaking fluids, and a cervix that was neither dilated nor effaced. His repeat ultrasound confirmed intrauterine fetal demise. He recommended that Ms. Morin go home, take acetaminophen/codeine for her discomfort, and follow up in the morning with her private obstetrician.

The patient didn't want to go home, so she pleaded with the EP to admit her until she delivered the dead fetus. The EP again called the obstetrician, who told him that Ms. Morin's cervix was not ready for delivery, so he discharged her over her and her fiancé's "vehement protests."[1] At around 9 p.m. later that day, Ms. Morin delivered the dead fetus in her bathroom at home.

Subsequently, Ms. Morin sued EMMC for damages and emotional distress,

alleging the hospital failed to stabilize her emergency medical condition (EMC) before discharge in violation of the Emergency Medical Treatment and Active Labor Act (EMTALA).[1,2]

The Federal District Court's Opinion

The medical center asked the federal court to dismiss the lawsuit, claiming that EMTALA did not apply to her care because she did not have an EMC as defined by the law.

EMTALA has two definitions for an EMC. First, a general definition that applies to any ED patient, but Ms. Morin did not argue that she had an EMC under this definition.[3] Instead, she claimed she had an EMC under EMTALA's second definition, a special provision for pregnant women, which holds that:

1) The term "emergency medical condition" means:

(B) with respect to a pregnant woman who is having contractions:

(i) that there is inadequate time to effect a safe transfer to another hospital before delivery; or

(ii) that transfer may pose a threat to the health or safety of the woman or the unborn child.[4]

Or explicitly in her case, that she was a pregnant woman who was having contractions and that her discharge ("transfer") posed a threat to her health or safety and, therefore, the hospital had a duty to "stabilize" her, which under the law requires the hospital to deliver the child and the placenta.[5] Thus, she claimed because she had an EMC under the pregnant women provision of the statute, the hospital had to keep her until she expelled the dead fetus and the placenta. (Note that under EMTALA, all discharges from the ED are legally defined as "transfers.")[6]

Was Ms. Morin in "True Labor" and, Thus, Having an EMC?

EMMC tendered a number of arguments for why Ms. Morin was not suffering an EMC under EMTALA and, thus, it had no duty to "stabilize" her in the manner required by EMTALA. The hospital's main arguments were:

Ms. Morin was not diagnosed as being in labor; therefore, EMTALA's obligation to stabilize her never applied. EMMC argued that labor refers to childbirth of a viable baby and not to miscarriage of a non-viable (less than 20 weeks) fetus.

The court was distinctly perturbed at "EMMC's disquieting notion that EMTALA would allow hospital emergency rooms to treat women who do not deliver a live infant differently than women who do."[1] It responded, first, that the plain language of EMTALA extends protection to any "pregnant woman who is having contractions;"[4] second, nothing in the statute or regulations depends on the gestational age or viability of the fetus; and third, other courts have ruled that EMTALA protections apply regardless of viability.[7] The court did not believe "Congress ever intended such a harsh and callous result for women who, like Ms. Morin, were carrying a non-viable fetus;" therefore, the court concluded that EMTALA's protections extended to pregnant women regardless of the fetus's viability.

In response, the hospital claimed that, "whether a pregnant woman is experiencing an emergency medical condition is not simply a legal determination, divorced from how physicians define and use terms like 'labor' and 'contractions,'"[1] trying to convince the court that the practice of medicine didn't consider miscarriages to be "labor" or "contractions," as contemplated by the statute.

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Please contact **Leslie Hamlin, Managing Editor**, at leslie.hamlin@ahcmedia.com.

The court noted that CMS' regulations state that:

"A woman experiencing contractions is in true labor unless a physician, certified nurse-midwife, or other qualified medical person … certifies that, after a reasonable time of observation, the woman is in false labor."[8,9,10]

And Ms. Morin argued since there was no certification of false labor in the medical record, the assumption was that she was in true labor, which she equated to having an EMC. The hospital countered that there could have been no certification by a physician that the plaintiff was "in false labor" because, medically, she would not have been considered by a physician to be in "false labor" (much less labor), since medical doctors do not define contractions at early stages of pregnancy as "labor." (The hospital seemed to miss the fact that the obstetrician documented in the medical record "discomfort like Braxton-Hicks contractions," which, by definition, are false labor.)

The court disagreed, stating bluntly for the first of many times in the case, that the medical practitioners' definition of an EMC was irrelevant under EMTALA; it was the legal definition that controlled for purposes of compliance with the law.[1] It noted that regardless of what the physician may diagnose, the regulation says that a pregnant woman who is experiencing contractions is in true labor unless the hospital certifies that she is in false labor.

This is where the court started wavering off the path of the statutory construction of EMTALA.

First, the word "labor" does not appear *anywhere* in the statutory definition of an EMC in a pregnant woman.[4] Thus, whether a pregnant woman is in "labor," "early labor," "active labor," or has "false labor" is *absolutely irrelevant* for legally determining whether she has an EMC under EMTALA.[11]

Second, in 1989, Congress amended the law, changing the definition of an EMC in pregnant women to specifically remove the word "labor" from the definition.[12] Thus, no one can reasonably assert that whether the woman is in true labor or false labor has anything to do with the determination of whether an EMC is present in a pregnant woman. This is clearly borne out every day in real medical practice: Hospital labor and delivery units routinely send women home in early labor when no complications are found, and it is determined safe to allow them to remain at home for a period of time until labor progresses further and warrants hospitalization for observation or delivery.

Third, even if the hospital does certify the pregnant woman with contractions to be in "false labor," that alone is ***not sufficient*** to rule out an EMC under the pregnancy definition of an EMC in EMTALA. Review the definition again: "The term 'emergency medical condition' means with respect to a pregnant woman who is having contractions:

(i) that there is inadequate time to effect a safe transfer to another hospital before delivery, or

(ii) that transfer may pose a threat to the health or safety of the woman or the unborn child.[4]"

Regardless of the certification of false labor, the hospital must still comply with the statutory requirement that it be safe to transfer her to another hospital before delivery AND that the transfer, or discharge to home in Ms. Morin's case, not pose a threat to her health and safety. (Since the fetus was already dead, there was no issue with the health and safety of the unborn child in this case.) Thus, any time a physician declares the woman in false labor, he or she must ALSO determine and opine that the discharge will not pose a threat — which is why the determination of whether a woman is in "true labor" or "false labor" is legally irrelevant for determining compliance with EMTALA.[13]

In other words, there are ***three*** elements to the pregnancy definition of an EMC under EMTALA: the existence of pregnancy, the presence of contractions, and the threat to the health and safety of the woman and unborn child related to transfer or discharge.

The court understood that the relevant question for Ms. Morin's failure to stabilize claim was not whether Ms. Morin was in labor, but whether she was "experiencing" or "having contractions;" however, it seemed to allow that "true labor" was an EMC that required stabilization, and permitted testimony on this issue at trial.[1]

Did the Hospital Diagnose Ms. Morin to Have an EMC?

EMMC's primary argument was really the crux of the case. It contended that before it could be held liable for failure to stabilize Ms. Morin's EMC, it must first determine that the EMC exists. In this case, that means it must have made the actual determination that all three elements of the pregnancy definition were present. The hospital essentially conceded the first two elements, pregnancy and contractions, so the sole key issue was whether it determined and knew that the discharge of Ms. Morin posed a threat to her health and safety.[1,14] (Interestingly, the hospital never offered one very strong argument — that Ms. Morin was NOT pregnant! The fetus was dead; therefore, at the time of her ED visit, she was no longer "pregnant," which, by definition, means carrying a developing embryo or fetus.)

The federal appellate courts have uniformly held that "determining the EMC exists" is an actual knowledge requirement, meaning that the hospital must subjectively, actually know/make the diagnosis that the EMC is present before it has a duty to stabilize that EMC.[15] Therefore, at trial, plaintiffs have the burden of proving the hospital had actual (subjective) knowledge that such a threat existed. Not that the hospital or physicians "should have known" a threat existed (the malpractice standard), or that they considered "threats" in their differential diagnosis … but that the hospital *actually knew and made that determination*.[16,17]

Although, unfortunately, documentation is key; if hospitals don't really understand EMTALA's scheme for pregnant patients, then it is unlikely and very difficult for them to properly document the necessary determinations in the medical record to reflect its considerations of the EMTALA issues before discharging the woman. Furthermore, this concept of proving subjective knowledge/actual knowledge is difficult for lay persons to comprehend during a trial.

The court in *Morin* agreed with the federal appellate courts: Ms. Morin would have to prove at trial that EMMC determined an EMC existed and knew that her discharge may pose a threat to her health and safety.[1]

However, the court viewed the "may pose a threat" language as a very low hurdle, and required only a "showing of possible threat" or "the presence of a possible threat of harm" to the health and safety of the mother.[1,18] Furthermore, in keeping with the seminal civil case on this point, *Burditt v. HHS*, the standard for "may pose a threat" under EMTALA "does not require proof of a reasonable medical probability that any threat will come to fruition."[19] The court noted that Congress rationally required less of a showing of probability and severity of harm for pregnant women than the general population under its emergency definition.[19]

Thus, the judge ruled that it was "a question of fact" and that the jury would decide whether EMMC subjectively knew that the discharge of Ms. Morin may pose a threat to her health and safety.[1]

The court did not mean to suggest that the discharge of every pregnant woman who is having contractions "may pose a threat to her health," but it did state, "Instead, here, where the hospital discharged a woman who is 16 weeks pregnant, who has just been informed her fetus is dead, who is having ongoing contractions, and who is in an extreme state of agitation and distress, the Court readily concludes that the Plaintiff presents sufficient evidence to allow the matter to proceed to trial."[1]

The Court concluded that if Ms. Morin was pregnant and having contractions, EMMC was obligated to allow her to remain at the hospital until she delivered the fetus and the placenta, unless her discharge would not pose a threat to her health or safety.[1]

Jury Trial and the Verdict

The trial should have been limited to whether the hospital had "actual knowledge" of the EMC (i.e., did it subjectively know that Ms. Morin was pregnant, had contractions, and that discharge may pose a threat to her health and safety). If it did have actual knowledge of the three elements of an EMC, the case was over, since the only way it could stabilize the EMC was by delivery of the fetus and the placenta, and that obviously didn't happen. If it didn't diagnose Ms. Morin with an EMC (i.e., it didn't know that discharge would pose a threat to her health and safety), the case was over this way too, since then, EMTALA would no longer apply and the hospital would not have had a duty to stabilize her by keeping her until she delivered the fetus.

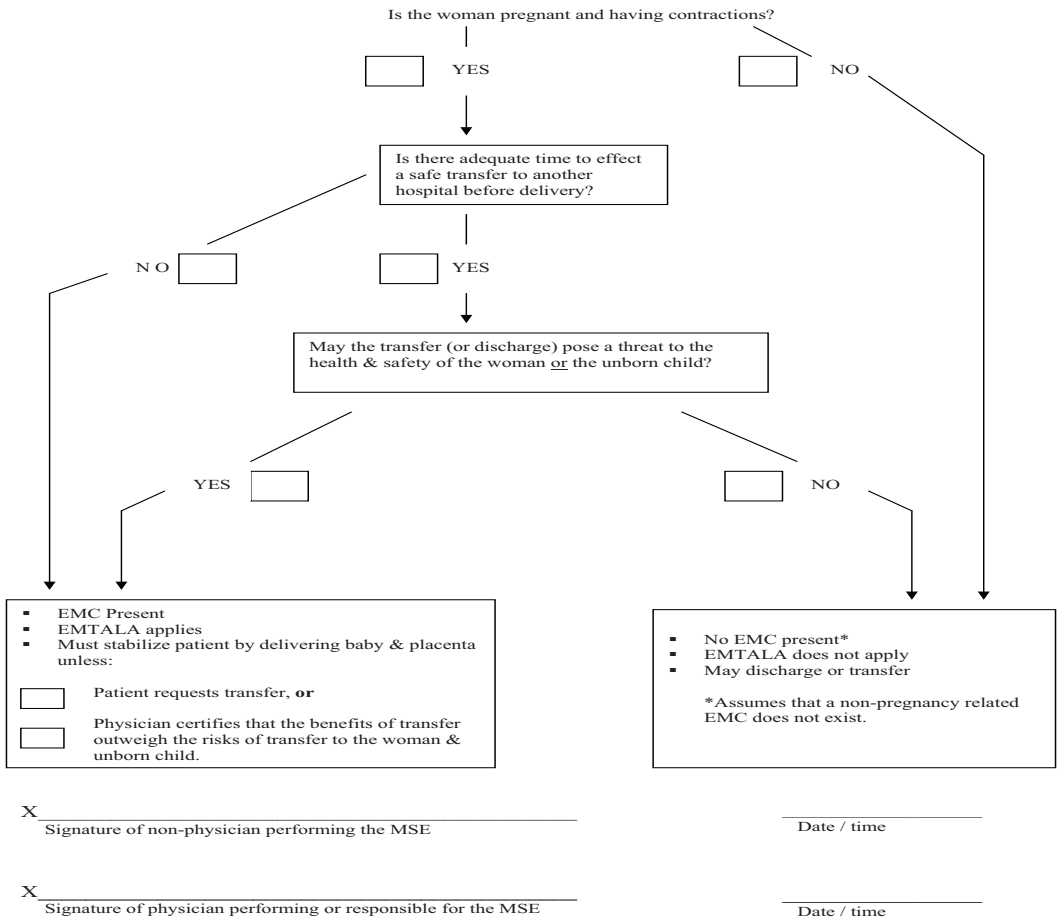
Therefore, the only evidence admitted at trial should have been evidence that directly addressed exactly what the hospital had determined and what it knew at the time it discharged Ms. Morin.

Evidence from the medical record, testimony by the participants, and expert opinion bearing only on what was known to the hospital at that time was relevant.

The court acknowledged, correctly, that under EMTALA, the case was not about the standard of care. Yet, the case really became a standard-of-care exposé and the result was most likely due to the jury's outrage at the alleged callousness of the hospital regarding the patient's request for admission, inadequate pain control, "extreme state of agitation and distress," and lack of grief counseling (that would have been available had she been admitted), "delivery of her fetus on a cold, hard tile floor in her bathroom at home," and the fact that the hospital staff clearly missed some historical risk considerations that it shouldn't have in its decision-making process to send the patient home, such as a previous C-section or past history of post-partum depression; the fact that she lived an hour and half from the hospital, so it wouldn't be easy to come back if she developed complications; lack of attempt to call the patient's own obstetrician, despite her requests, etc.

The case really wasn't about law; it was more about raw human emotion and lack of compassion or concern for a fellow human being in a time of severe emotional distress (as the $150,000 in punitive damages attests). Did the hospital recognize her needs and concerns? Did it adequately listen/communicate with her on the relevant issues and illicit the necessary information and circumstances to make a reasoned

Figure 1: Obstetrics Medical Screening Exam Compliance with EMTALA



decision? It is true that EDs send a significant number of these women home but also admit a significant number depending upon those circumstances.

Additionally, when sending someone home over the vehement objections of the family and of a patient who just lost a baby, the physicians and hospital had better be right and communicate and document their reasoning profusely. Couple anger with an adverse outcome and you breed litigation.

Undoubtedly in this case, the EP, the on-call obstetrician, the nurses, and the hospital had no idea of the EMTALA-mandated criteria they were required to use to judge whether the patient had an EMC under the law, and whether it was safe or reasonable to send the patient home under those criteria. Proper documentation, coupled with knowledge of the low threshold standard under the law, would have markedly improved the chances of the hospital avoiding the adverse financial and public-relations outcome of this case.

Interestingly, post verdict, and after the judge denied the hospital's motion for a new trial, a representative of the hospital commented that EMMC was confident that the appellate court would find that the hospital's treatment of Ms. Morin was consistent with long-standing national practices.[20] "Long-standing national practices" are irrelevant if they don't comply with EMTALA.

Comment

One can understand the jury's decision, but, in truth, it was likely based more on their belief in the standard of care (and caring) that should have been provided to Ms. Morin than on the nuances of EMTALA. But the distinction is highly important because, if otherwise, it would turn every decision on whether a patient has an EMC into an EMTALA violation instead of a standard-of-care issue, which is wholly removed from the actual intent of the law.

It's no different than if a 55-year-old smoker who presents with chest pain, is diagnosed with heartburn, but dies of an acute myocardial infarction a few hours after leaving the ED. The EP may have misread the EKG, failed to obtain the right history, which would have pointed to ischemic heart disease,

or misinterpreted the diagnostic enzyme studies, but those are what he "should have known" or "should have done" standard-of-care issues — a failure to diagnose claim under state law, not an EMTALA claim for failure to stabilize the patient.

Similarly, assume a 3-month-old infant with a high fever diagnosed with a "viral syndrome" is discharged from the ED to follow-up with the pediatrician in the morning, but returns with obvious sepsis before the appointment. A plaintiff's attorney can argue that the EP should have recognized the sepsis, should have started antibiotics, should have ordered more diagnostic studies, or should have admitted the child, but he can't argue that the hospital failed to stabilize the sepsis, because the hospital didn't know the child was septic. It did not determine that the child had that particular EMC, or any other not-yet-diagnosed EMC.

Furthermore, including the possibility of sepsis in the differential diagnosis, considering the diagnosis of sepsis (such as evidenced by sending off a blood culture), being concerned about the potential for the diagnosis, or even having expert testimony certain that the physician *should have* determined the child was septic are all irrelevant for purposes of EMTALA.[16] The issue is whether the physician/hospital ***subjectively*** actually knew — actually determined that fact, and it should be readily apparent by the medical record and the discharge of the child to follow-up the next morning that it did not.

Call it an error in judgment or medicine delivered below the standard of care, but it is not a violation of EMTALA, and the physician/hospital cannot be held liable for failure to stabilize an EMC that they didn't actually know existed. Liable under state law standards of care, yes, but not liable under EMTALA.

Conclusion

The EMTALA statute, not this court or this jury's decision, long ago required hospitals and physicians to learn, understand, and apply the legal lingo required by the law to evaluate and process pregnant women with contractions through their EDs and labor and delivery departments. Pregnant women are a protected class under EMTALA and, as such, there is a very low threshold for error under the law. The care of these individuals will be highly scrutinized by the government enforcement agencies, as well as the courts.

Moreover, probably no other clinical scenario generates more emotion or attracts more adverse publicity, government retribution, and/or litigation than the perception that a hospital or a physician mistreated or denied care to a pregnant woman. This is one area of hospital-based practice in which being legally correct simply isn't enough. The evaluation of obstetric patients must be not only medically appropriate and lawful but also must be perceived to be in the best interests of the patient. Cultivating and projecting an attitude of genuine advocacy for the patients' interests at all times is paramount. Perception is the only reality.

Hospitals should adopt a risk-management approach to evaluating pregnant women. They should implement policies and procedures that maximize conformity to standard medical practice, ensure compliance with the law, and minimize regulatory and liability risks. This process includes educating all staff involved, conducting ongoing quality assurance and performance monitoring, and ensuring appropriate documentation. Checklists, forms, and algorithms must imbed knowledge of the law, but they must also be practical, user-friendly tools that guide physicians and hospital staff down the proper pathways, even if they don't understand the legal issues or their implications.

The Maine federal court's rulings and the jury's verdict really changed nothing. They did, once again, highlight the fact that many hospitals have yet to comprehend the broad scope of EMTALA's reach and its significant impact on the practice of medicine.

As the *Morin* court noted in quoting a 1991 appellate court opinion, "EMTALA's statutory definition renders irrelevant any medical definition."[19] Hospitals have been quite slow to truly accept the fact that this statute forever changed emergency medicine to be a practice governed by law, and no longer a practice governed primarily by acceptable standards of care. ■

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Can a Family Sue if You Allege Abuse Is Occurring, and It's Not?

Good faith reports are protected

When an emergency physician (EP) reported suspected child abuse, he inadvertently gave the wrong family's information to the authorities, and the child was removed from the home. If you were the EP in question, would you expect to be on the receiving end of a lawsuit?

In fact, the family did sue the EP, but the court ruled that the physician had reported in good faith and had made an honest mistake, says **Gregory P. Moore**, MD, JD, an attending emergency medicine physician at Madigan Army Medical Center in Tacoma, WA.

Moore says this case emphasizes that EPs who report child abuse are protected under the law. "The law wants to protect children, and it places a high priority on that," he says. "We all have a right to privacy, but sometimes the law will allow you to violate a constitutional right for the greater good. Child abuse is a perfect example."

Moore says he knows of several cases to which an EP did *not* report clear cases of abuse, which resulted in successful lawsuits. "Physicians are supposed to report even a suspicion, and if they don't, they would be liable," he says. "They are not going to go after guys that are just trying to follow the rules. If you report in good faith, you will not get in trouble."

Failing to Report

Failing to report child abuse, however, carries significant legal risks for EPs, says Moore. In one case, a child was brought to multiple ERs with broken bones and other injuries, and eventually was killed. "The mother was put in jail and the father appeared and successfully sued," he says. "There were multiple injuries over multiple time periods, which is a red flag, but no one pursued it."

Robert Broida, MD, FACEP, COO of Physicians Specialty Limited Risk Retention Group in Canton, OH, says that emergency personnel are at far greater risk by *failing* to report suspicion of child abuse than by reporting. "In addition to potential criminal penalties in many states for failure to report, any subsequent harm to the child may be attributed to this failure in a malpractice action," adds Broida.

Possible damages from reporting suspicions that are later determined to be unfounded might include parental anguish and emotional distress, says Broida. "Most attorneys won't touch such a case. I have seen several of these cases, and all were dropped fairly quickly," he says.

On the contrary, says Broida, the damages from failure to report might be a brain-damaged baby needing skilled nursing care for life. "This is where the financial damages are, and with them, the serious liability concerns," he says. "Do not hesitate to report *any* suspicion, even if it's a third-hand rumor or nonspecific concern. Let the authorities sort it out."

EPs Are Protected

In order to sue an EP successfully for reporting abuse, says Moore, a person would have to prove that the reporting was done maliciously, which would be difficult.

Because the law requires physicians and medical staff to report any suspicion of child abuse or neglect, the law also protects physicians from the legal fallout from making those reports, says **Robert D. Kreisman**, a medical malpractice attorney with Kreisman Law Offices in Chicago.

"The law assumes that all physician reports of abuse or neglect are made in good faith," says Kreisman. "The physician is immune from any civil or criminal liability that might result from the report."

Arthur R. Derse, MD, JD, FACEP, professor of bioethics and emergency medicine at the Medical College of Wisconsin, says that the standard of evidence for reporting abuse is "extremely low."

"That is, EPs and nurses merely need to have a suspicion of child abuse," he says. "The legislatures in all 50 states have given EPs and nurses wide room to be able to report this suspicion."

For this reason, says Derse, it's extremely unlikely that an EP or ED nurse could be successfully sued for negligence for an abuse allegation that was made in good faith.

"The legislatures have decided to err on the side of reporting child abuse, rather than not," says Derse. "If an allegation is made in good faith, the worst that's happened is an unfounded allegation. If a report is not made and the child dies from abuse, you have paid for that error with the price of the life of a child."

EPs Will Win Cases

In a 2009 federal case, *Mueller v. Auker*, 576 F. 3d 979, an Idaho EP reported child neglect to authorities because a parent refused to allow her infant to be given a spinal tap to rule out a life-threatening infection. As a result, the state was allowed to take custody of the child under the child-protection laws so the procedure could be done.

The family sued, alleging a violation of their federal constitutional rights. The federal appellate court ruled that the lawsuit against the EP could go forward. "The appellate court wasn't ready to give the EP the benefit-of-a-doubt protection for reporting, in this particular case, by dismissing the lawsuit," says Derse. However, at trial, the federal jury sided with the hospital and physician.

"That is the only case I'm aware of in which the case against the EP was *not* dismissed by the court, when the evidence supported that the EP acted in good faith by reporting. Even so, the EP in this case was ultimately exonerated by the jury," says Derse.

A very small number of these cases have been brought over the years, says Derse, "but when acting in good faith, the EP inevitably wins."

If there *were* cases in which EPs were held liable for mistakenly reporting child abuse, says Derse, there would be the unintended effect of an increase in mortality in child-abuse cases because they weren't investigated early enough.

"In good faith" is a standard that applies when you are doing an action such as reporting possible abuse with sincere belief or motive without any malice toward the parent, he explains.

"This is one of the few areas where the legislature and tort law allow you to err in good faith without penalty," says Derse.

False Reports Can Be Prosecuted

Although the law protects those who make good-faith reports, says Kreisman, false reporting may be prosecuted as a crime. "A false report differs from an 'unfounded' report, which is when the Department fails to find credible evidence of abuse or neglect," he explains.

A false report involves the reporting physician or medical staff willfully making material misrepresentations in the report of abuse, says Kreisman. "The first time someone is found guilty of making a false report, as defined, it is considered a misdemeanor under the Criminal Code," he says. "However, any subsequent violations are elevated to a felony."

The law is less forgiving for individuals who willfully, falsely report abuse, are found altering or tampering with documentation, or attempt to protect someone from prosecution for child abuse, says Kreisman.

"In those cases, the violation is a felony. The physician or medical provider involved is referred to the state medical disciplinary board," says Kreisman. "The enjoyment of immunity from prosecution and/or civil lawsuit is therefore lost." ■

Know Legal Requirements for Abuse Reporting

All members of the ED staff, including physicians, residents, interns, and nurses, are mandatory reporters of child abuse and neglect, says **Robert D. Kreisman**, a medical malpractice attorney with Kreisman Law Offices in Chicago.

"That means that they are required to submit a written report to the appropriate local department whenever they suspect that a child they have observed may have been abused or neglected," says Kreisman. Here are Kreisman's recommendations to reduce legal risks:

Physicians and medical staff should be familiar with the legal definitions of abuse and neglect.

While each state may classify these terms differently, *child abuse* generally refers to physical or mental harm to a child, says Kreisman. Abuse can include sexual abuse, torture, administering non-prescribed, controlled substances, or placing the child at a substantial risk of being harmed, he says.

Child neglect refers to inadequate nourishment or basic care, such as providing food, clothing, and shelter, or abandonment without providing for proper care, says Kreisman.

Physicians should report any pregnant women who are addicted to alcohol or drugs, or when a newborn's blood, urine, or meconium contains any amount of controlled substances that are not accounted for by medical treatment, adds Kreisman.

The law sets out a few provisions that do not constitute neglect in the absence of any other incidences, says Kreisman: If a child is relinquished under the Illinois Abandoned Newborn Infant Protection Act, if the child is left alone under the care of an adult relative for a prolonged period of time, or if the parents choose to rely exclusively on prayer for the treatment or cure of a medical disease.

If child abuse or neglect is suspected, report it immediately.

Most states have a 24-hour hotline available for making an initial report, says Kreisman, and the process typically involves making an oral report, which is confirmed in a detailed written report within 48 hours.

The initial oral report should include some general information, Kreisman says, including the name and address of the child and his or her guardians, the child's age, the nature of the abuse or neglect, and any other information or evidence that the reporter feels could be helpful in demonstrating that there was abuse or neglect.

The written report also includes the name and address of the child's school, the child's race, the names and ages of other family members living with the child, and the name, occupation, and contact information for the person making the report, says Kreisman.

Specify what actions were taken to document the abuse.

Kreisman says to include whether photographs or X-rays were taken, whether the child was placed in temporary protective custody, and, in the case of a death from suspected abuse, whether the medical examiner or coroner was notified.

Any documentation that raised a suspicion of abuse or neglect should be submitted, in Illinois, to the Illinois Department of Children and Family Services, says Kreisman, including current medical exams, which may contain statements or interviews, scans, laboratory reports, and past medical exams that might have suggested abuse or neglect.

"It is the responsibility of the Department to investigate child abuse," says Kreisman. "The role of the emergency department staff is to faithfully report any suspicions of abuse or neglect."

Remember that the privileged communication relationship that exists between physicians and patients does *not* excuse the duty to report abuse.

"Once a report has been made, all of the documents in that written report are admissible as evidence in the judicial proceedings that might arise from the reported child abuse or neglect," says Kreisman. ■

Sources

For more information, contact:

- **Robert Broida, MD, FACEP,** Chief Operating Officer, Physicians Specialty Limited, Risk Retention Group, Canton, OH. Phone: (330) 493-4443. E-mail: rbroida@emp.com.
- **Arthur R. Derse, MD, JD,** Professor, Bioethics and Emergency Medicine, Institute for Health and Society, Medical College of Wisconsin, Milwaukee. Phone: (414) 955-8498. E-mail: aderse@mcw.edu.
- **Robert D. Kreisman,** Kreisman Law Offices, Chicago, IL. Phone: (312) 346-0045. Fax: (312) 346-2380. E-mail: bob@robertkreisman.com. Web: www.robertkreisman.com.
- **Edward Monico, MD, JD,** Department of Surgery, Section of Emergency Medicine, Yale University School of Medicine, New Haven, CT. Phone: (203) 785-4710. E-mail: edward.monico@yale.edu.
- **Gregory P. Moore, MD, JD,** Emergency Department, Madigan Army Medical Center, Tacoma, WA. E-mail: GMoore4408@aol.com.

Privacy vs. EP Duty to Report Could Be Focus of Lawsuit

Very little literature or case law exists to shed light on the circumstances that might result in litigation against health care providers for allegedly making false reports of suspected abuse of adult ED patients, according to **Edward Monico**, MD, JD, assistant professor in the department of emergency medicine at Yale University School of Medicine in New Haven, CT.

"In fact, the existing literature and case law concentrates on the exact opposite scenario — the *failure* to report abuse when it should have been suspected," adds Monico.

If a patient did sue because a report of suspected abuse was unfounded, Monico says that the lawsuit would likely focus on the confrontation between the patient's right to privacy and the duty on the part of the health care provider to report suspected or proven abuse.

"Attempting to elicit victim consent will go a long way to mitigate later allegations that a patient's right to privacy was violated," he adds.

Specifically, says Monico, while physicians take an oath to maintain the confidentiality of the doctor-patient relationship, they may be forced to violate that trust in order to comply with certain state laws. "Some commentators have maintained that it offends an individual's autonomy to require or encourage reporting of mistreatment over a competent adult's objection," he says.

With increasing awareness of domestic violence as a major public-health problem, many states have developed policy initiatives that attempt to compel health care practitioners to better respond to the problem, says Monico. "Most states have imposed some sort of affirmative duty on the part of health care providers to report suspected abuse," he says.

Most of these laws protect health care practitioners who report in accordance with the law, explains Monico, by providing them with immunity from civil and criminal liability.

Anticipate Immunity

"The 'in accordance' language contemplates that the report of abuse would rest on some degree of *reasonableness*," says Monico. For example, he says, New Mexico requires that anyone who has reasonable cause to believe an adult has been abused report that knowledge or be guilty of a misdemeanor.

Similarly, says Monico, California law provides that any health practitioner employed by a health facility, clinic, or physician's office, and acting within the scope of employment, must make a report to the appropriate legal authorities concerning any person that the practitioner knows, or reasonably suspects, has suffered a wound or injury inflicted by the use of a deadly weapon or resulting from assaultive or abusive conduct.

"Lawmakers clearly anticipate that some investigations of reported abuse will uncover no abuse at all," says Monico. "Health care providers should anticipate immunity, as long as their suspicions are anchored on reasonableness."

This relies on the EP knowing what wounds, scenarios, and complaints should arouse a reasonable suspicion of abuse, says Monico. Document these signs and symptoms, he advises, and cite hospital protocols, if possible, when making reports of suspected abuse.

"Not unlike risk reduction for medical malpractice, the best strategies to reduce risk associated with mandatory reporting center on practicing good medicine," says Monico. ■

Nurses' Notes Conflict With EP's? Don't Let It Go Unacknowledged

Succinctly address disagreements

Does the EP's charting indicate that a patient was discharged home, while an ED nurse's documentation states, "The patient looks very sick and I don't think he should be discharged," go unacknowledged without any additional explanation?

If the patient's chart contains an important difference of opinion, like this one, it's a mistake to just ignore it, according to **Frank Peacock**, MD, vice chief of emergency medicine at The Cleveland (OH) Clinic Foundation. Peacock says that if a bad outcome occurs and the case goes to trial, bias will generally go to the person who knows the most about the patient — in this case, the EP. "I'm the guy who did the long H&P and talked to all the consultants, so I have more details to play with," he says.

Peacock recommends succinctly addressing the nurse's statement in this scenario, with documentation such as, "The patient is at baseline. I have read the nurse's notes and do not agree."

The EP may notice that a patient's blood pressure

was documented as 50 by the triage nurse, but the patient is moving around and seems fine. In this case, Peacock suggests documenting, "Although the nurse documented the blood pressure as 50, the clinical grounds suggest this is an erroneous measurement."

Be Above Board

A typical situation is that an ED nurse may chart that a patient has chest pain, and the doctor may determine that it's actually abdominal pain, according to **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 Temple University Clinical Campus, Pittsburgh.

"If that is, indeed, true, and the patient does not truly have chest pain, you could do nothing at all with the documentation and just leave it be. But, that is a high-risk situation," he says.

Anytime you encounter a chart inconsistency, says Vukmir, "it is medicolegally prudent to address and reconcile it. But do it in an above-board manner." An example of this, says Vukmir, would be, "The nursing record suggests that chest pain was the chief complaint, but to my own exam, I found it to be abdominal pain."

"Remember that physicians and nurses, although working shoulder to shoulder, are still two different administrative arms," says Vukmir. Resolving the inconsistency with a nursing peer is, in some ways, better than having an EP do this, adds Vukmir.

If an EP is concerned about an inconsistency, he advises going to the charge nurse. "If you found abdominal pain and the nurse found chest pain, ask him or her to help you reconcile that," Vukmir says. "Ask, 'Would you mind having another nurse go back and do a reassessment to help clarify the situation?'"

Changes in Story

There may be discrepancies between what the triage note says and what the patient later states. For instance, the triage notes report a history of fever, which the patient now denies, or the EP's more detailed history reveals that a patient's severe headache resolved a week ago.

"Patients sometimes misunderstand the line of questioning and want to tell you everything, related or not," says **Hartmut Gross**, MD, a professor of emergency medicine at Medical College of Georgia in Augusta. "In the din of the ED, staff members may misunderstand what the patient is saying."

Gross tries to pinpoint these misunderstandings, and documents statements such as, "Even though the triage note says …" or "The patient now adds …" He also specifically asks the patient about what the triage staff has documented. "It gives the patient a chance to correct what I thought they told me or specifically refute what was documented by someone else," he says. ■

Sources

For more information, contact:

- **Hartmut Gross, MD,** Department of Emergency Medicine, Medical College of Georgia, Augusta. Phone: (706) 721-7144. E-mail: hgross@mail.mcg.edu.
- **W. Frank Peacock, MD,** The Cleveland Clinic Foundation, Department of Emergency Medicine, Cleveland, OH. Phone: (216) 445-4546. Fax: (216) 445-4552. E-mail: peacocw@ccf.org.
- **Rade B. Vukmir, MD, JD, FACEP,** Critical Care Medicine Associates. Phone: (412) 741-7018. E-mail: rbvmd@comcast.net.

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 INSTRUCTIONS

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2. Log on to **www.cmecity.com** to take a post-test; tests can be taken after each issue or collectively at the end of the semester. *First-time users will have to register on the site using the 8-digit subscriber number printed on their mailing label, invoice, or renewal notice.*

3. Pass the online tests with a score of 100%; you will be allowed to answer the questions as many times as needed to achieve a score of 100%.

4. After successfully completing the last test of the semester, your browser will be automatically directed to the activity evaluation form, which you will submit online.

5. Once the evaluation is received, a credit letter will be sent to you. ■

CNE/CME QUESTIONS

1. Which is recommended if an EP discovers information in the nursing notes about a patient's condition that he or she does not believe is accurate, according to Frank Peacock, MD?
   A. The EP should not address the nurse's statement specifically in the chart.
   B. The EP should succinctly address the nurse's statement.
   C. The EP should avoid asking another ED nurse to perform a reassessment.
   D. The EP should never ask the patient directly about what the nurse has documented.

2. Which is true regarding the legal risks of an EP reporting suspected abuse that turns out to be unfounded, according to Robert D. Kreisman?
   A. Physicians are required to report only clear cases of abuse, not mere suspicions that abuse may be occurring.
   B. Significant damages are likely with lawsuits involving unfounded abuse allegations, due to emotional distress.
   C. The law assumes that all physician reports of abuse or neglect are made in good faith, and the physician is immune from any civil or criminal liability that might result from the report.
   D. Many successful lawsuits have occurred in which EPs were held liable for mistakenly reporting child abuse, even in good faith.

3. Which is true regarding an EP *failing* to report child abuse, according to Robert Broida, MD, FACEP?
   A. Emergency personnel are at far greater risk for reporting abuse that turns out to be unfounded, than for failing to report suspicion of child abuse.
   B. In addition to potential criminal penalties in many states for failure to report, any subsequent harm to the child may be attributed to this failure in a malpractice action.
   C. The privileged communication relationship that exists between physicians and patients excuses the duty to report abuse.
   D. None of the documents in a written report of child abuse or neglect are admissible as evidence in the judicial proceedings that might arise as a result of the report.

4. Which is true regarding false reports of abuse, according to Robert D. Kreisman, a medical malpractice attorney in Chicago?
   A. The law protects those who report abuse, even if the reporting physician willfully makes material representations in the report of abuse.
   B. The first time someone is found guilty of making a false report, it is considered a felony under the Criminal Code.
   C. A false report is no different from an "unfounded" report, when there is failure to find credible evidence of abuse or neglect.
   D. The first time someone is found guilty of making a false report, it is considered a misdemeanor under the Criminal Code, but any subsequent violations are elevated to a felony.

Dear *ED Legal Letter* Subscriber:

This issue of your newsletter marks the start of a new continuing medical education (CME)/continuing nursing education (CNE) semester, and provides us with an opportunity to tell you about some new procedures for earning CME/CNE.

ED Legal Letter, sponsored by AHC Media, provides you with evidence-based information and best practices that help you make informed decisions concerning treatment options and physician office practices. Our intent is the same as yours — the best possible patient care.

The objectives of *ED Legal Letter* are:

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

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3. Pass the online tests with a score of 100%; you will be allowed to answer the questions as many times as needed to achieve a score of 100%.
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Sincerely,

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Valerie Loner
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