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Does a Phone Call from a Clinic or Physician's Office Signify the Patient Has "Come to the ED" for the Purpose of Triggering EMTALA Obligations?

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Contributing Editor

Kansas court rules that a patient had not "come to the emergency department" by virtue of a clinic physician calling and asking the hospital to accept the patient. Furthermore, the court determined that EMTALA's duty to accept a patient in transfer is only actuated when the hospital is called by another hospital, not by a clinic or physician's office.

The Case of *Penn v. Salina Regional Health Center*[1]

Theresa Penn presented to a Kansas primary care clinic with crushing chest pain radiating to her neck, jaw, and both arms. Ms. Penn's physician, Dr. Yoxall, examined her and determined she was experiencing an acute myocardial infarction — a life-threatening emergency. Dr. Yoxall called Salina Regional Health Center because Salina was the closest hospital with an emergency room and "specialized facilities." Salina was a "supporting hospital" for the clinic, but there was no relationship of any kind between the two entities with legal significance under EMTALA (The Emergency Medical Treatment and Labor Act — 42 USC 1395dd).[2]

Dr. Kauer, the on-call cardiologist at Salina, took the phone call but declined to accept Ms. Penn, ostensibly because there were no beds open in the intensive care unit. Consequently, Ms. Penn was taken by ambulance to another hospital 85 miles from Salina. She suffered a cardiac arrest en route and died a few hours after arriving at the second hospital. The ambulance service that transported Ms. Penn was not owned by, or in any way affiliated with, Salina Regional.[1]

Ms. Penn's family sued Salina Regional for violating EMTALA, claiming that the hospital failed to provide Ms. Penn a medical screening exam, failed to provide stabilizing treatment, and failed to accept her in transfer from the Kansas primary care clinic, as requested by her physician.[1]

Did Salina Regional Have a Duty to Screen and Stabilize Ms. Penn Under EMTALA?

Under EMTALA, a hospital must provide medical screening and stabilizing care if, and only if, there is a request for examination or treatment of a medical condition, and the individual has "come to the emergency department" — which the government CMS (Centers for Medicare & Medicaid Services) and the courts have interpreted to mean anywhere on hospital property, including in a ground or air ambulance owned and operated by the hospital.[2]

Ms. Penn's physician obviously requested emergency care for her, so the whole case boiled down to whether Ms. Penn had "come to" Salina Regional. The answer may seem simple and obvious, but the terms "simple" and "obvious" are rarely congruent with government regulations or court interpretations of law.

The plaintiffs, faced with the incontrovertible facts that Ms. Penn never reached Salina Regional property and was not transported in a Salina Regional ambulance, asserted the requirement that a patient "comes to" the emergency department was met by Dr. Yoxall's phone call from the primary care clinic to the hospital requesting emergency services. They pointed out that other courts have accepted such an expansive interpretation of the "comes to" language of EMTALA.[1]

For example, in two civil cases, federal appellate courts held that once an ambulance contacts a hospital, the patient has "come to the emergency department" for purposes of triggering EMTALA obligations on that hospital. Each time, the hospital's emergency physician had re-routed the patient to another hospital farther away via telemetry orders to the medics in the ambulance.[3,4]

In the first case, *Arrington v. Wong*,[3] a non-hospital owned ambulance began transporting a Hawaiian man suffering a heart attack to Queen's Medical Center, the nearest hospital. The medics radioed ahead to alert the hospital of their arrival and offered (or in response to the emergency physician asking who was the patient's regular doctor) that the patient typically went to Tripler Army Medical Center, 5 miles away from Queen's. The emergency physician then opined, "I think it would be OK to go to Tripler," whereupon the medics diverted to Tripler, where the patient died shortly after arrival.[3]

The Arrington family sued Dr. Wong and Queen's Medical Center under EMTALA, convincing the court to stretch the "comes to the ED" language to include phone contact from a non-hospital owned ambulance that was not on hospital property. Additionally, the 9th Circuit Court ruled that once the ambulance was en route to the hospital, the hospital could not divert the ambulance elsewhere unless it was on "diversionary status."[3]

The second case cited by the plaintiffs was *Morales v. Sociedad Espanola de Auxilio Mutuo y Beneficencia*, which, in turn, relied on the Arrington decision.[4] In the Morales case, a patient with a potentially ruptured ectopic pregnancy was in a non-hospital owned ambulance on the way to the ED of a Puerto Rico hospital when the paramedics contacted the emergency physician on duty. Allegedly, the phy-

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sician inquired as to whether the patient was medically insured or a member of the hospital's insurance program. Upon learning of her uninsured status, the physician abruptly terminated the call, which the paramedics interpreted as a refusal to accept the patient into the hospital's ED. Feeling stymied, the paramedics took the patient elsewhere.

Again, a suit was filed claiming the hospital violated EMTALA. The plaintiff argued that once the paramedics decided to take her to the hospital, started driving in that direction, and had contacted the physician in the emergency department to facilitate her arrival, she had, for all practical purposes, "come to" the hospital, and that she was rebuffed due to her lack of insurance.

Again, the issue was whether the patient had "come to" the hospital's emergency department, and once more, the court, citing the Arrington decision, ruled for the plaintiff and allowed the lawsuit to proceed.

Furthermore, the Morales court agreed with the Arrington court that the hospital could not turn away an individual in a non-hospital-owned ambulance that had not yet reached hospital property unless it was on "diversionary status."[4]

Must a Hospital Be on Diversionary Status Before it Can Divert an Incoming Ambulance?

Both appellate courts relied on the EMTALA regulations promulgated by CMS to reach their conclusion.[5] The relevant section related to "comes to the emergency department" and "diversionary status" is:

Comes to the emergency department means …the individual — is in a ground or air non-hospital-owned ambulance on hospital property for presentation for examination and treatment of a medical condition at a hospital's dedicated emergency department. However, an individual in a non-hospital owned ambulance off hospital property is not considered to have come to the hospital's emergency department, even if a member of the ambulance staff contacts the hospital by telephone or telemetry communications and informs the hospital that they want to transport the individual to the hospital for examination and treatment.

The hospital may direct the ambulance to another facility if it is in ''diversionary status,'' that is, it does not have the staff or facilities to accept any additional emergency patients. If, however, the ambulance staff disregard the hospital's diversion instructions and transport the individual onto hospital property, the individual is considered to have come to the emergency department.[6]

The Arrington court interpreted these four sentences to mean that only if the hospital was on diversion could it re-route a non-hospital-owned ambulance before it arrived on hospital property. It essentially ignored CMS' simple and obvious declaration in the second sentence that a person in a non-hospital owned ambulance off hospital property has *not* come to the ED, even when the medics call the hospital expressing their desire to bring the patient there.[3]

The Morales court found these four sentences "imprecise," "ambiguous," and "absent of reliable guidance" from CMS.[4] So it decided to look to legislative intent, rather than the plain language of the statute ("comes to the hospital's emergency department") or the regulations to decide when an individual in a non-hospital owned ambulance had "come to" the ED. It believed the law must be interpreted in a way that prevents hospitals from "dumping" patients, enhancing the ability of indigent individuals to receive timely emergency care, and thwarting hospitals' efforts to turn away prospective patients because of their economic status, fits most squarely with this intent.[4]

The court believed that to hold otherwise would create perverse incentives associated with EMS diversion, stating that, "If a hospital were allowed to turn away an individual while she was en route to the hospital, an uninsured or financially strapped person could be bounced around like a ping-pong ball in search of a willing provider. That result would be antithetic to the core policy on which EMTALA is based."[4]

It also believed that this interpretation would preserve the salutary practice of ambulances contacting hospitals prior to arrival when perceived emergencies exist, "enabling the EDs to undertake suitable preparatory measures." It did not want the ambulance staff to fear refusals because of the lack of medical insurance and, instead, present to the ED "under cover of silence." True, EMTALA would require the ED to examine and treat the individual upon arrival, but precious time would be lost.[4]

The Morales court ended its discussion, commenting that it was a "close and difficult case," and that CMS "has the authority, should it choose to act, to resolve the ambiguity either way. To this date, however, HHS has not done so. Unless and until that occurs, we must do the best we can …"[4]

Interestingly, CMS' guidance was originally contained only in its interpretive guidelines, not in its

regulations. After the Arrington case decision, CMS proposed codifying the guidelines into regulations. The medical/legal professions asked CMS to change/clarify the language, primarily seeking to prevent future court rulings similar to the Arrington decision of the 9th Circuit, or, at least, make its position on the issue known to all. Instead, CMS specifically stated it would not comment on the Arrington decision, and did not clarify the issue one way or another; it simply inserted the critical language of the guidelines into the regulations — the same regulations that later would confuse and confound the 1st Circuit in the Morales case.[7]

The *Penn* Court Disagreed with the Appellate Courts in the Arrington and Morales Cases

The district court in *Penn* declined to accept the decisions of other circuits, finding that their interpretation was "diametrically opposed" to the regulatory definitions. Instead, it accepted the opinion of the dissents in Arrington and Morales, which interpreted the "comes to" language to require that the patient be physically present on hospital property to trigger EMTALA. Phone calls from non-hospital-owned ambulances en route didn't count, and the Penn court considered the rulings of the appellate courts to be "strained attempts to make EMTALA apply to tragic factual scenarios." In other words, based on emotion rather than law.[1]

It believed the meaning of the first and second sentences was evident simply by reading them: an individual in a non-hospital-owned ambulance has not "come to" the emergency department unless and until he or she is on hospital property. The second sentence is a manifest expression of CMS' intent to exclude from this category those who merely call ahead.

It interpreted the third sentence to be simply one scenario (i.e., when the hospital is on "diversionary status") under which the hospital could deny access to an individual in a non-hospital-owned ambulance that called ahead, but not the only scenario under which it could deny access.

The fourth sentence then explains the legal ramifications if the ambulance staff ignore the hospital's rejection and show up on hospital property or at the ED anyway (which, in my opinion, is the only reason CMS included the third sentence — it wanted hospitals to fully comprehend that they had an EMTALA duty to provide emergency care to indigent patients who presented to their EDs in spite of the hospital's efforts to keep them away). The fourth sentence also affirms CMS' intent that in order to have "come to" the emergency department for EMTALA purposes, the patient must actually be physically on hospital property.[1]

Did Salina Regional Have a Duty Under EMTALA to Accept Ms. Penn in Transfer from the Clinic?

Lastly, the court examined whether Salina Regional had engaged in "reverse dumping" by failing to accept an appropriate transfer in violation of EMTALA's non-discrimination clause, which reads:

"A participating hospital that has specialized capabilities or facilities (such as burn units, shock-trauma units, neonatal intensive care units, or [with respect to rural areas] regional referral centers …) shall not refuse to accept an appropriate transfer of an individual who requires such specialized capabilities or facilities if the hospital has the capacity to treat the individual."[8]

Salina Regional agreed it was a "participating hospital," since it was a hospital that had entered into a Medicare provider agreement under section 1395cc of the Social Security Act, as defined by EMTALA.[9]

However, Salina argued that EMTALA and its regulations do not apply when a clinic or physician's office attempts to send a patient to a hospital. It claimed that for a hospital to be liable under EMTALA for "reverse dumping," the request for transfer must come from another hospital, not a clinic or physician's office.[1]

The court agreed, noting that participating hospitals need only accept appropriate "transfers," and the term "transfer" is defined by EMTALA to mean "the movement ... of an individual outside a hospital's facilities at the direction of any person employed by (or affiliated or associated, directly or indirectly, with) *the hospital*."[10]

The court considered "the mind-numbing definition of 'hospital,'" set out in the Medicare statute, then easily ruled that the clinic or Dr. Yoxall's office was not a "hospital" and, therefore, Salina Regional had no duty under EMTALA to accept a patient from them.[11]

The plaintiffs floated one last balloon, arguing that the clinic or Dr. Yoxall's office constituted implied or de facto "dedicated emergency departments," since many patients come directly to the clinic for emergent care, in part because of the clinic's association with another hospital. The court rejected that argument, using language very apt to really understanding EMTALA: "There is no room in the definition-heavy environment of EMTALA law and regulations for 'implied' or 'de facto' constructions." Definitions really do matter when considering whether EMTALA applies to any patient

encounter.[1] Note, too, that critical access hospitals are included in the definition of "hospital" for purposes of EMTALA.[12]

In the end, the court said it is apparent that "reverse dumping" requires two hospitals: a "transferring hospital" and a "specialized transfer accepting hospital."[1]

Comment

The decisions in this case, assuming they are upheld on appeal, are good news for hospitals providing EMS telemetry directions to ground and air ambulances and to hospitals asked to accept patients from non-hospital settings, such as outlying clinics or physician offices.

"Comes to the emergency department" should mean actual physical presence on hospital property. If CMS tells an employee to "come to work by 9 a.m.," it certainly will not pay the individual for the hour he claims to be "at work" because he is "coming to the building" by 9 a.m. but doesn't show up until 10 a.m. EMTALA cannot be used to solve all problems within the health care system. EMS telemetry alone should not constitute "comes to the ED" to attach EMTALA duties a hospital, regardless of whether or not the hospital is on "diversionary status."

Furthermore, the regulatory language states that the hospital may not divert the ambulance if it can accept "any additional patients." What if the hospital has the capacity to accept medical patients, but not major trauma patients at that time, and the ambulance calling is asking to bring in a trauma case? It would be appropriate to divert the ambulance because that hospital at that time would not be an appropriate place to take the patient. Often hospitals are able to accept some types of patients, such as non-urgent cases, but not the type of patient in the ambulance, such as a major trauma case or a patient in need of a service the hospital lacks, such a neurosurgery.

Additionally, patients are often directed to other facilities because of patient preference, family preference, previous extensive treatment at the other facility, physician preferences, and medically indicated reasons such as required specialty care. It doesn't do the head trauma patient any good to bring him or her to a hospital that lacks a neurosurgeon.

Medical direction decisions are complex and made with inadequate information. They are essentially "educated guesses" based on experience, training, and judgment, and made in good faith to achieve the best possible care for the patient. If EMTALA attaches to medical direction decisions, emergency physicians and hospitals may cease participation in community EMS medical control systems.

Witness what occurred in Chicago after the *Johnson v. University of Chicago* case (an infant in cardiac arrest was re-routed farther away because the hospital was on "partial EMS bypass" for pediatric cases).[13] There was such uproar from the provider community that the court changed its opinion sua sponte (on its own accord), from finding the hospital liable under EMTALA to stating that the law didn't apply to phone calls from non-hospital-owned ambulances, because otherwise no one would participate in EMS medical direction due to the additional civil liability under EMTALA.[13] Why would hospitals and physicians risk $50,000 civil monetary penalties for ordinary negligence, costly interminable Medicare termination investigations and proceedings, and federal civil liability for a considerate service they are providing entirely gratis to their communities?

Furthermore, if EMTALA, which is a federal law, applies to EMS direction, it preempts the ability of the individual states to legislatively provide liability protection to EMS medical control physicians and hospitals for provision of this community service. Most states currently do provide some qualified liability protection in this arena. If EMTALA is expanded to medical control decisions, it would preempt those protections because of the supremacy clause of the U.S. Constitution. See, for example, Illinois' Emergency Medical Services Act, which immunizes an EMS telemetry system operator from liability for any activity that does not constitute "willful or wanton misconduct."[14]

So what does an emergency physician do when he or she believes it's appropriate to divert an ambulance to another facility? Always act in the best interest of the patient, not what is safest for one's self or the hospital from a legal perspective. Redirect patients to the most appropriate facility based on established community EMS protocols. Don't even ask about the patient's insurance or managed care status; instead, base all decisions solely on the legitimate individual medical issues of each case rather than diverting patients based on economic or other non-medically indicated reasons. Document your decisions accordingly.

Finally, be "crystal clear" in your directions to the ambulance personnel. The emergency physician in the Arrington case claimed that he was merely agreeing with the medic's decision that it was OK to reroute to the patient's regular hospital. However, the medics testified that they believed that the physician ordered them to the other hospital. ■

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Suits Possible for Failure to Report Child Abuse

Err on the side of reporting

Michael Gerardi, MD, FAAP, FACEP, director of pediatric emergency medicine at Goryeb Children's Hospital in Morristown, NJ, reports that he is aware of several recent lawsuits naming an emergency physician (EP) for failure to diagnose child abuse.

"The child is seen for what is perceived as a minor injury and no one connected the dots pointing to abuse because the stories of how the injury occurred seemed truly accidental," says Gerardi. "Subsequently, the child was severely abused or murdered."

Daniel M. Lindberg, MD, an attending physician in the Department of Emergency Medicine at Brigham and Women's Hospital and assistant professor of medicine at Harvard Medical School, both in Boston, says he knows of many EPs who saw an injured child and later learned they had failed to detect abuse, but isn't aware of any lawsuits involving this.

"The key is to do everything you can not to miss it. When you do miss it, good documentation doesn't help you very much," he says. Inevitably, the EP documents that the family had a good interaction and that there were no red flags, but this doesn't mean much if a lawsuit is filed alleging missed abuse, Lindberg explains.

You should not document the fact that you still had some concerns for abuse when the patient left, but chose not to report for some reason or another, advises Lindberg. "Since physicians are mandated reporters throughout the United States, you are putting yourself out there by doing this," he says.

It is far better to report a concern and communicate to Child Protective Services that you aren't 100% sure abuse exists, than not report and leave the concerns hanging, says Lindberg.

ID High-risk Injuries

Systematic screening for child abuse in the ED increases the detection of suspected child abuse, according to a just-published study that screened 104,028 children presenting at seven EDs in the Netherlands from February 2008 to December 2009.[1]

EPs should know which injuries are low, moderate, or high risk for abuse, advises Gerardi. For instance, he says, a spiral humerus fracture reflects moderate to high risk, while a spiral tibia fracture in a toddler is very low risk. Bruises on certain parts of the body, such as the shin, are low risk, but bruises on the spinal column are highly suggestive of abuse.

Certain injuries should always make EPs consider abuse, even if the child has never been injured before, says Lindberg. To screen for other injuries, he recommends that EPs perform and document a thorough physical examination including the ears, the fontanel (if open), lips, frenula, palate, teeth, genitalia, and skin.

"If you screen carefully and you don't find anything and you decide not to report it, I think most people understand that you thought about it and tested for it," Lindberg says. "That is a decision that is more defensible."

Be Matter-of-fact

Skeletal surveys should be obtained regardless of physical examination findings for contacts of injured,

abused children who are younger than 24 months old, according to a recent study.[2] Twenty U.S. child abuse teams used a screening protocol for the contacts of physically abused children with serious injuries, and identified at least one abusive fracture in 16 of 134 contacts, none of which had associated findings on physical examination.

"These results are especially important for EPs because they have the chance to talk to families early before the involvement of law enforcement, child protective services, and lawyers on all sides," says Lindberg, the study's lead author. "A non-judgmental, matter-of-fact approach can help ensure that siblings are evaluated without making it a fight."

He says that EPs might try saying something like, "The injuries we've found are more than we would expect for the kind of injury that you reported. In cases like this, it's important to look at other kids in the family to make sure we aren't missing violence or other dangerous medical diagnoses."

The EP's decision to report shouldn't be based on risk factors such as poverty or young parents, advises Lindberg. "Those factors impact the risk for abuse the same way that blood pressure impacts the risk for heart disease," he says. "People abuse their kids with none of those red flags, and most people with all of the red flags take excellent care of their kids."

It's more helpful to look for injuries that are uncommon, and use a systematic, unbiased approach that doesn't depend on having a parent lose his or her temper in the ED, says Lindberg. To reduce legal risks, he recommends that EPs "think less about risk factors than about the injuries they are seeing, and whether or not other injuries are identified."

Err on Side of Caution

Samantha L. Prokop, JD, an attorney with Brennan, Manna & Diamond, LLC, in Akron, OH, says that the one piece of advice she always gives clients in a state that offers immunity for reporting suspected child abuse, is that it is better to err on the side of caution and report. (To view a Child Abuse and Neglect Reporting State Statute overview, go to http://bit.ly/OcX6zK.)

"Failure to report may lead to not only criminal penalties, but also private causes of action for negligence," she adds.

In one case, a child was brought to the ED with symptoms of intestinal colic and his mother later sued the EP, his employer, and the hospital that treated the patient, alleging a violation of the Illinois abuse and neglect reporting statute. Plaintiffs also alleged that the defendants breached a common law duty that medical professionals owe to their patients.[3]

The court held that the EP had no common law duty to discern the child's 5- to 8-week-old rib fractures, which allegedly resulted from abuse, while diagnosing and treating the colic issues.

"In light of this case, ED physicians may have more leniency in the duty to recognize and report abuse due to the focused and episodic care they provide," says Prokop. A primary care physician with access to a lengthy medical history will likely have more information available to identify and report suspected abuse than would an EP, who likely has no prior records available and is focusing on a specific treatment issue, she adds.

Document social service consults and efforts made to report abuse, advises Prokop, and charting "no abuse suspected" may help refresh an EP's recollection as to his or her state of mind if an issue arose in the future. However, nursing documentation indicating unexplained injuries, history of violence, or reported prior abuse could be used to show suspicion of abuse that should have been reported, she cautions.

"If there is enough documentation in the chart to give the provider reasonable suspicion of abuse or neglect, he or she should err on the side of reporting, as this documentation would likely be used against the practitioner in a subsequent suit," she says. ■

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Assess for These Red Flags for Abuse

Below is a list of some things that EPs should consider to be red flags for abuse, according to **Daniel M. Lindberg**, MD, an attending physician in the Department of Emergency Medicine at Brigham and Women's Hospital and assistant professor of medicine at Harvard Medical School, both in Boston:

- Serious brain injury after a reported short fall;
- Serious injury reported to be inflicted by a young (pre-verbal) sibling;
- Unexplained delay in seeking care;

• History changes over time or between caregivers;
• No history offered to explain serious injury;
• Bruising in children who can't "cruise;"
• Oral (labial, sublingual) frenulum tears in children who can't cruise;
• Bruising to the abdomen, ears, genitals, neck;
• Patterned bruises or burns;
• Retinal hemorrhages;
• Subdural hematoma in a child < 24 months old;*
• Rib fractures in children < 24 months old;*
• Long-bone fracture in infants < 12 months old;*
• Abdominal organ injury in children < 24 months old;* and
• Multiple fractures in different stages of healing.*

*Concern for abuse isn't usually raised when these injuries are found after a motor vehicle crash, or after a serious trauma witnessed by several disinterested people. ■

Sources

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"Concussion Laws" *Do* Affect ED Legal Risks

The "concussion laws" passed by 39 states establish an expectation for emergency physicians (EPs) involved in the case of a student athlete who has potentially suffered a concussion to have "a very low threshold" for making the diagnosis of concussion and removing the child from any potential for further injury, says **Roger J. Lewis**, MD, PhD, a professor in the Department of Emergency Medicine at Harbor — UCLA Medical Center in Torrance. *(For more information on laws of specific states, go to: http://bit.ly/QdmHOc.)*

"It's important that EPs are very clear in their documentation, and in their communication with parents, that a concussion is a clinical diagnosis and the symptoms can be very subtle," says Lewis.

Concussion laws should make ED providers more attentive to kids they see with concussion, says **Douglas S. Diekema**, MD, MPH, an attending physician at Seattle (WA) Children's Hospital. "Our attitude should not be that it is 'just a concussion,'" he says. "Ten years ago, we really didn't fully appreciate the importance of cognitive rest for young athletes with concussive symptoms."

It's now the EP's job to make sure that parents and kids understand that they should not only refrain from athletic effort, but also from activities requiring increased cognitive exertion, says Diekema.

Many states with concussion laws require that an athlete be cleared by a health care professional before returning to organized sports, adds Diekema. "Parents should be told about these requirements, and ideally, provided with a referral to trained specialists that provide these follow-up exams," he says.

Adequately Warn Parents

Diekema says that the two biggest liability risks he sees for ED physicians lie in failing to warn parents that premature return to activity may have lasting negative effects on their child's brain, and failing to notify them of any state laws requiring medical clearance before return to play.

"Return to play guidelines have become standard practice," he notes. "So even in states without these laws, parents and older children should be told that they should not return to any athletic activity until their symptoms have completely resolved and they have been seen by a trained health care provider in follow-up."

EPs should be very clear with parents that their child still could have suffered a concussion even if the child doesn't exhibit symptoms during the ED visit, stresses Lewis. "The definition of concussion is a transient alteration in level of consciousness after impact. Most of the time, the child will have a normal exam at the time of evaluation," he says. Common symptoms include headache and difficulties with concentration, sleep, and emotional lability, says Lewis.

EPs face legal risks if they fail to communicate that the child must be absolutely symptom-free without medication prior to beginning a stepwise return to play process, Lewis warns. "Symptoms of a concussion are so subtle that they can't be detected just by talking to a child, he says. "You cannot rule out a concussion just based on a physical exam."

Concussion laws make it even more important that parents and older children be provided with

information about the dangers of concussion, the dangers of not allowing for a complete recovery, instructions to avoid both physical and cognitive exertion until symptoms have resolved, and return to play guidelines, says Diekema.

Diekema says that he treats all kids like athletes, even those who suffered their concussion during unstructured play. "I tell parents that they should not allow their child to do those things that might risk a second head injury until the child's symptoms have completely resolved," he says. "This might include climbing trees, riding bikes and skateboards, and rough-housing."

In order to identify that a patient has suffered a concussion, EPs need knowledge of the potentially subtle symptoms of concussion, and familiarity with the various clinical tools for testing for concussive symptoms like the Sport Concussion Assessment Tool 2 (SCAT2), Diekema says. *(The tool can be viewed at http://bit.ly/PGVUYB.)*

"There is a pervasive but incorrect belief among laypeople and among some physicians that a negative CT scan is useful in the assessment of concussion, or in contrast, that imaging is necessary for children with symptoms of concussions," adds Lewis.

Should EP Clear for RTP?

Lewis notes that some state concussion laws specifically state that an athlete suspected of sustaining a concussion shall not be permitted to return to the activity until he or she is evaluated by a licensed health care provider trained in the management of concussions, and acting within the scope of his or her practice.

Lewis says that this means that EPs should not clear children to return to play unless they believe they have personally received adequate training, are aware of the current recommendations for return to play guidelines, and can document that they've instructed the parent to ensure that those guidelines are followed. *(To view the Centers for Disease Control and Prevention (CDC) guidelines, go to http://1.usa.gov/PgtcLP. The International Concussion Consensus Guidelines can be viewed at http://bit.ly/eUMiJ6. Also see related story, p. 117, on whether an EP should give written clearance to return to play.)*

The purpose of the ED visit is to rule out serious intracranial injury, not to make a decision about return to play, which is a multistep process, emphasizes Lewis. Decisions regarding starting a standard return to play protocol should be made "only after a period of recovery, so symptoms can clarify themselves," he says. "Since the normal recovery time is one to four weeks, the decision regarding return to play is certainly not an emergency."

If an EP is satisfied that there is no serious intracranial injury using standard guidelines, the EP should generally not be recommending that children return to play until they are re-evaluated by a physician with expertise in this area, says Lewis.

The standards for assessing and managing concussions have evolved very quickly, adds Lewis, and a relatively small number of EPs were taught the current guidelines during their residency training. "So it behooves EPs to take some time to read the CDC guidelines and make sure these are incorporated in their practice and written instructions they provide," says Lewis.

"If the child suffered an injury, it is not OK for the EP to say, for example, 'As soon as your headache goes away, you can go back to play.'" says Lewis. "Such a recommendation would put the EP at substantial risk." ■

Is the EP Qualified to Give Clearance?

Concussion laws often require evaluation to be done by a particular class of health care provider — one trained in the evaluation and management of a concussion, says **William M. McDonnell**, MD, JD, an associate professor of pediatrics in the Division of Pediatric Emergency Medicine at University of Utah in Salt Lake City.

"Concussion laws may inject a degree of uncertainty as to whether particular physicians can, or should, evaluate patients with concussions," he says.

There is no widely accepted medical consensus on which professionals are trained in the evaluation and management of a concussion, notes McDonnell. "Education related to traumatic brain injuries is a component of every medical school curriculum. Thus, arguably all physicians have such training," he says.

Since neurologists are highly trained in long-term management of neurologic injuries, some might interpret concussion laws as requiring evaluation of every child with a concussion by a neurologist, says McDonnell, while others might argue that specific training in acute traumatic injuries, including concussion, is most extensively addressed in emergency medicine and trauma training programs, and, therefore, ED evaluation is required for all such patients.

"As a result of this lack of clarity regarding physicians who are qualified to perform the evaluation, schools and other organizations justifiably may be concerned about potential liability under concus-

sion laws, and may err on the side of caution," says McDonnell.

Accordingly, sports organizations may insist that all children with concussions receive ED or neurology specialist evaluations, when less costly medical evaluations in many cases might be more appropriate, says McDonnell.

"Uncertainty regarding which medical professionals must provide the medical evaluation may increase ED referrals, as schools and community organizations seek to comply with the law," he says.

Written Clearance

Concussion laws often require that a health care provider provide "written clearance" before the child may resume participation in a sporting event, notes McDonnell. "However, 'written clearance' has no uniformly accepted definition in the medical or legal literature," he says.

It is possible that despite appropriate medical evaluations and treatment, courts and/or juries in medical malpractice cases will interpret such "written clearances" as guarantees that the child will suffer no future adverse events related to the head injury, says McDonnell.

By directing health care providers to provide "written clearance," concussion laws may effectively make those providers responsible for choices more properly delegated to parents, and may imply that the health care providers can guarantee outcomes.

McDonnell says that ED physicians might reduce their potential liabilities by taking the following steps:

- Establish and follow a clear institutional "concussion protocol," with evidence-based processes for return-to-play clearance and clear discharge instructions;
- Clarify in the chart, and in conversations with the parents, what "clearance" to return to play means — that reasonable medical standards indicate that the child may return to play, but that the parents must consider the child's individual risks and benefits of returning to play, and that clearance is not a guarantee against adverse outcomes;
- Firmly resist pressure from parents and coaches to "clear" a child to return to play when relevant medical evidence and practice guidelines indicate that additional treatment or evaluations are indicated;
- Facilitate outpatient follow-up with appropriate specialty providers for patients who cannot be cleared under the institution's concussion protocol. ■

Sources

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Tougher Standards for Proving ED Malpractice?

Burden is greater for plaintiffs

If the plaintiff had to prove beyond a reasonable doubt that an emergency physician (EP) made a wrong decision, "there are so many gray zones in medicine that there would never be a plaintiff judgment again," says **Kevin Klauer**, DO, EJD, chief medical officer for Emergency Medicine Physicians in Canton, OH, and a member of the board of directors at Physicians Specialty Ltd. Risk Retention Group.

States including Arizona, Texas, Florida, Georgia, South Carolina, Utah, and West Virginia have all successfully enacted some degree of special liability protection specifically for emergency care providers. This approach to tort reform is "very different from caps that would limit the amount of damages," says Klauer, and instead, focuses on the standards for burden of proof and duty of care.

In most states, the burden of proof to prove ordinary negligence is simply a preponderance of evidence, notes Klauer. "Contrast that to criminal cases, where no one gets put in jail unless the case is proved beyond a reasonable doubt. That is the instruction that the jury would get," he says.

In contrast, a preponderance of evidence standard means there is "simply enough evidence that tips you over beyond the 50% mark. Then you have proven ordinary negligence, and there will be a plaintiff's verdict," says Klauer.

One tort reform strategy, says Klauer, is to "up the

ante" for the standard of burden of proof from a "preponderance of evidence" to "clear and convincing."

Duty of Care

The current standard for duty of care is what a reasonable provider would do under similar circumstances, says Klauer. "We are all familiar with that," says Klauer. "But some states have tried to get a 'willful and wanton' standard for the duty of care." This means that in order to prove negligence, the plaintiff would have to prove that the physician actually tried to harm the patient or knew something would harm the patient and did it anyway.

"One step down from that is gross negligence. Basically, that is synonymous with recklessness," says Klauer. An example, he says, would be an EP who has never done a procedure before, and either knew or should have known it would harm the patient.

Michael Frank, MD, JD, General Counsel for Emergency Medicine Physicians, testified on behalf of the Ohio chapter of the American College of Emergency Physicians before the Ohio Senate Committee considering the state's immunity bills, both in 2009 and 2011. The original bill in 2009 proposed applying the "willful or wanton misconduct" standard for abrogating immunity, however.

"But last year, the bill had been watered down to applying immunity only if the alleged conduct did not display 'reckless disregard.' That is a considerably lower standard than 'willful or wanton misconduct,'" says Frank.

Reckless disregard is defined in the bill as "conduct that a physician ... knew, or should have known, at the time those services were rendered, created an unreasonable risk of injury, death, or loss to person or property so as to affect the life or health of another, and that risk was substantially greater than that which is necessary to make the conduct negligent."

The "willful or wanton misconduct" standard survived in the provisions of the bill applicable to services provided in a disaster, but not to most emergency services provided pursuant to EMTALA, says Frank, and the immunity also does not apply to cases alleging wrongful death.

A judge in a malpractice case can always decide whether to allow a case to get to a jury, or decide to dismiss it, as a matter of law, because the plaintiff cannot make a case that meets the applicable standard, whether that standard is "willful or wanton misconduct" or "clear and convincing evidence."

But because the "willful or wanton misconduct" standard is so much more difficult for a plaintiff to overcome, a judge is much more likely to throw out a case (and a plaintiff is much less likely to file the lawsuit in the first place) than if the standard is "clear and convincing evidence," says Frank.

"'Clear and convincing evidence' is still a huge evidentiary hurdle for plaintiffs," says Frank. "But better to never get to a jury in the first place."

A national standard would be ideal, says Klauer. "But I just don't see that coming in the near future at all. All the activity for tort reform is on a state level," he says. "And there could be some repeals." In Georgia, the burden of proof standard was maintained, but the elevated duty of care standard was repealed, he notes.

A "gross negligence" standard of duty should reduce the number of cases in which a patient is compensated simply because a bad outcome occurs, says Klauer.

"When things just didn't work out quite right, people are penalized because of that. Careers are ended and physicians commit suicide over these cases," he says. "This is a way to say to the public and to plaintiff attorneys, 'Our hearts are in the right place and we are trying to do the best we can with limited resources. Maybe the standard of duty is too high and the burden for the plaintiff is way too low.'" ■

To view pertinent legislative language from the states that have helped successfully enact legislation that provides some degree of special liability protection specifically for emergency care providers, along with copies of similar bills introduced in other states and related talking points, legislative testimony, and report findings, go to: http://www.acep.org/Advocacy/Pursuing-Special-Liability-Protection-for-Emergency-Care.

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

1. Which is recommended to reduce liability risks involving failing to report child abuse, according to **Daniel M. Lindberg**, MD?
   A. EPs should document that the family had a good interaction and that there were no red flags, because this makes a missed abuse case very defensible regardless of what injuries the child presented with.
   B. EPs should always document if they still had some concern for abuse when the patient left, but chose not to report.
   C. EPs should report concerns and communicate to child protective services that the EP isn't certain that abuse exists, instead of not reporting and leaving the concerns unaddressed.
   D. EPs should make the decision to report based largely on risk factors for abuse such as poverty.

2. Which is true regarding documentation to reduce legal risks involving missed abuse in the ED, according to **Samantha L. Prokop**, JD?
   A. EPs should avoid documenting social service consults.
   B. If EPs chart that no abuse is suspected, this is legally protective even if abuse is missed.
   C. If documentation in the chart is enough to give the provider reasonable suspicion of neglect, this is legally protective even if the provider does not report.
   D. If there is enough documentation in the chart to give the provider reasonable suspicion of abuse or neglect, he or she should err on the side of reporting, both to protect the child, and because this documentation would likely be used against the practitioner in a subsequent suit.

3. Which is recommended to reduce risks of ED malpractice involving children with suspected concussions, according to **Douglas S. Diekema**, MD, MPH?
   A. EPs must warn parents that premature return to activity may have lasting negative effects on their child's brain, and notify them of any state laws requiring medical clearance before return to play.
   B. It is not advisable for EPs to inform parents about state concussion laws requiring that an athlete be cleared by a health care professional before returning to organized sports.
   C. A decision about return to play should always be made during the ED visit.
   D. EPs are always qualified to clear children to return to play even if they don't believe they have personally received adequate training in the management of concussions.

CNE/CME INSTRUCTIONS

HERE ARE THE STEPS YOU NEED TO TAKE TO EARN CREDIT FOR THIS ACTIVITY:

1. Read and study the activity, using the provided references for further research.

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. ■