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An Ambulance 'Owned' by a Hospital Must Also Be 'Operated' by the Hospital to Trigger EMTALA Obligations

By Robert A. Bitterman, MD, JD, FACEP
Contributing Editor

Federal Circuit Court of Appeals ruling diminishes hospital liability under EMTALA related to hospital-owned ambulances.

Whenever an individual enters an ambulance (or medical helicopter) *"owned and operated"* by a hospital, the federal government deems the person to have "come to the hospital's emergency department" for purposes of triggering the hospital's obligations under the Emergency Medical Treatment and Labor Act (EMTALA).[1] Thus, even if the ambulance is not on hospital property, the hospital has a legal duty to provide medical screening and/or stabilization to that person in the ambulance.[2]

This EMTALA duty begs a number of questions. Does this mean the hospital-owned ambulance must transport the patient back to the hospital's own ED for examination and treatment? What if the patient should be taken to a closer, "more appropriate" hospital? What if the ambulance is directed by operation of community-wide EMS protocols?

The Case of *Beller v. Wishard Memorial Hospital*[3]

Facts. A Wishard Hospital ambulance was dispatched to the Beller home via a county 911 call. The paramedics ascertained the patient to be 34 weeks pregnant with a prolapsed umbilical cord. The medics tried to relieve pressure on the cord, and after consulting with a nurse at the mom's obstetrician's office, transported the patient to the nearest hospital, which did not have an obstetrics facility, rather than to Wishard Hospital. The accepting hospital promptly transferred the mom, in the same Wishard ambulance, to a tertiary facility, which performed an

emergency cesarean section, but the child ended up with severe hypoxic brain damage.[3]

Allegations. Beller sued Wishard Memorial Hospital under EMTALA for failure to stabilize the obvious emergency medical condition. The plaintiffs alleged that the mom was in an ambulance "owned and operated" by Wishard and, as a consequence, had "come to the ED" of Wishard. Therefore, Wishard had a legal duty under EMTALA to stabilize the emergency by delivering the child, rather than transferring mom to another hospital.[3-5]

The hospital admitted it *"owned"* the ambulance, but argued that it didn't *"operate"* the ambulance because the ambulance was instead controlled by community-wide emergency medical services (EMS) protocols. Therefore, the hospital contended that since the mom had not "come to the emergency department," it had no EMTALA obligation to screen or stabilize her emergency condition.[3]

District Court Rulings. The incident occurred in 2001, so the court looked to the Centers for Medicare and Medicaid Services (CMS) regulations in effect at the time, which simply stated "comes to the emergency department," meaning that the person is on "hospital property." CMS included "ambulances owned and operated by the hospital" as hospital property even if the ambulance was not on hospital grounds.[6]

Wishard contended that the standard practice was to "sidestep" this interpretation to avoid applying the definition of "comes to the emergency department" to hospital-owned ambulances that served as community-wide emergency response vehicles. The court, however, while granting that it may have been standard practice at the time, still determined that the regulations created a genuine dispute as to whether plaintiffs had "come to the emergency department" under the law, and, thus, it was for a jury to decide.[3] Interestingly, neither the hospital nor the court cited CMS' interpretive guidelines then in effect, which expressly stated that "compliance with local, state, or regionally approved EMS transport of individuals with an emergency is usually deemed to indicate compliance with EMTALA."[7]

Wishard also argued that two exceptions to the "comes to the ED" definition, which CMS promulgated in 2003, applied retroactively to the facts in this case and, therefore, the hospital could not be held liable as a matter of law. These exceptions were:

• An ambulance owned and operated by the hospital is not considered to have "come to the hospital's emergency department" if:

(i) the ambulance is operated under community-wide EMS protocols that direct it to transport the individual to a hospital other than the hospital that owns the ambulance; for example, to the closest appropriate facility.

(ii) the ambulance is operated at the direction of a physician who is not employed or otherwise affiliated with the hospital that owns the ambulance.[8]

Initially, the court refused to consider the exceptions since they were part of the changes in the EMTALA regulations that CMS issued more than two years after the incident that gave rise to the lawsuit.[3] However, the court reversed itself after the hospital pointed to 7th Circuit case precedent,

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which allowed retroactive application of government regulations if they merely "clarified" the agency's interpretation of the statute and did not represent a "substantive change" in the definition.[9] Since it was clear that the hospital's ambulance was indeed operating under community-wide EMS protocols at the time it transported the mom to the nearest hospital, the court granted the hospital's motion to dismiss the case once it decided that CMS' 2003 regulations only "clarified" CMS' interpretation of when EMTALA applied to hospital-owned ambulances.[3]

The plaintiffs appealed, arguing that the new regulation was, in fact, a substantive change in the law, not merely a clarification of CMS' interpretation. Moreover, the plaintiffs asserted that even if CMS did characterize it as a clarification (which they claimed wasn't clear), the district court gave undue deference to CMS' determination and erred in failing to conduct its own analysis to ascertain whether the amendment was a substantive change or a clarification.[3]

Appellate Court Ruling. Applying CMS' 2003 rules retroactively depended on whether its 2003 amendment of the regulatory definition of "comes to the emergency department" was merely a clarification of the meaning of that phrase, or whether it represented a substantive change in the definition.[3]

Under U.S. Supreme Court precedent, "an administrative agency may not promulgate retroactive rules unless Congress provided the agency with express authority to do so and, even if such authority is given, an agency rule will not be accorded retroactive effect unless the agency uses language in the rule expressly requiring that result."[10]

The 7th Circuit Court noted, however, that not all rules or regulations create substantive changes — some simply clarify unsettled or confusing areas of law. Furthermore, since those rules merely restate what the law has always been according to the agency, rather than changing the law, they may be applied retroactively.[9]

CMS believed that EMTALA's reach over hospital-owned ambulances operating under EMS protocols had been a constant source of confusion for hospitals, in that an ambulance could be owned by a hospital but not operated under its direction.[11] It wanted to avoid federal requirements that were inconsistent with local EMS requirements.[12] Furthermore, CMS specifically stated that its reason for adopting the 2003 regulation was "to *clarify* the responsibilities of hospital-owned ambulances so that these ambulances can be more fully integrated with city-wide and local community EMS procedures for responding to medical emergencies" and "reiterations and clarifying changes are needed to ensure uniform and consistent application of policy and to avoid any misunderstanding of EMTALA requirements by individuals, physicians, or hospital employees."[13] Thus, it "clarified" that EMTALA does not apply if the ambulance is operating under a community-wide EMS protocol that requires it to transport the individual to a hospital other than the hospital that owns the ambulance.[12]

Lastly, the court deemed it entirely appropriate that the district court gave deference to CMS' determination that the changes were clarifications to its interpretation of the statute. Legal precedent requires the courts to accord great weight to the intent of the promulgating agency, and they will not overturn the agency unless the prior interpretation of the regulation is "patently inconsistent" with the later one.[9]

The court found that the 2003 definition merely provided "clarifying" guidance as to what it means for an ambulance to be "operated by" a hospital.[3] The 2003 amendment specifically clarified the status of two situations in which the ambulance was owned by the hospital but not as a practical matter operated by the hospital during that time — first in which the ambulance is operated under community-wide EMS protocols that direct it to transport the individual to a hospital other than the hospital that owns the ambulance, and second in which it is operated at the direction of a physician who is not employed or otherwise affiliated with the hospital that owns the ambulance.[8]

It ruled that CMS' intent was to clarify its interpretation of EMTALA with respect to hospital-owned ambulances operating under community-wide EMS protocols, and this was the quintessential classic situation of a clarifying regulation. Therefore, the 2003 amendment applied retroactively to this case.[3]

Comment

This case and the interpretation by CMS of when a hospital-owned ambulance "comes to the ED" for purposes of triggering EMTALA make perfect sense. It would create havoc in the EMS world if the federal government pre-empted or prohibited communities from establishing system-wide protocols that control the utilization and flow of ambulances operating in their medical-

alert zones. Considering a number of recent scenarios submitted may help explain the various ramifications of EMTALA on hospital-owned ambulances.[14]

Senario 1. An instructor for The Advanced Cardiac Life Support course (ACLS) was concerned one of the course test questions didn't provide enough information to answer correctly.

ACLS Question: You receive a radio report from EMS en route to your hospital with a patient who may be having an acute stroke. The hospital's CT scanner is not working at this time. What should you do in this situation?

ACLS Answer: Divert the patient to a hospital 15 minutes away with CT capability.

The instructor was troubled by the fact that the question didn't state whether the EMS unit was owned by the hospital; or, if the EMS unit was not hospital-owned, whether it was on hospital property at the time of the radio call. If we assume the EMS unit was operating under community-wide protocols, then ownership of the ambulance wouldn't matter, because in either case, the ambulance would not have been "*operated by*" the hospital, so EMTALA wouldn't apply. Similarly, even if the ambulance was on the hospital's property, it could be diverted to a more appropriate hospital without triggering EMTALA's duty to screen or stabilize because CMS would not deem the patient to have "come to the ED" for purposes of triggering EMTALA under its clarifying regulations.

Scenario 2. Hospital A wanted to use its hospital-owned ambulances for two different purposes: first, to participate in the community-wide EMS system operating under its protocols; and second, to do "home health checks" on patients who are the high-users of EMS and the hospital's emergency department to keep them medically stable and reduce utilization of emergency services. The hospital was worried about the application of EMTALA, particularly whether its ambulance staff (or the ED itself) would be required to do medical screening exams on these patients, as well as over its potential liability under EMTALA if it did not transport the patient to a hospital, either its own ED or another nearby ED.

First, if the hospital-owned ambulance is responding to a 911 call:

Once the patient is in the ambulance, the patient has "come to the ED" for purposes of EMTALA. However, there still must be a "request" of the hospital for examination or treatment for a medical condition before EMTALA is triggered (i.e., both prongs must be met) — "comes to the ED" ***and*** the "request." If the patient doesn't request to go to the hospital, or if the patient refuses examination or treatment, there is no EMTALA duty.

If the patient never gets in the ambulance (i.e., the medics attend to the patient in his home and don't move the patient to the ambulance), then the patient has never been on hospital property (in the ambulance) and, therefore, there is no EMTALA duty.

Second, if it's a scheduled visit, not a 911 call:

A scheduled visit would meet the CMS definition of a "scheduled outpatient encounter" to which EMTALA does not apply, even if the patient is on hospital property (including in the ambulance) and makes a request for emergency care.[15]

Furthermore, if the medics discover an emergency condition that requires transport to a hospital emergency department, EMTALA would still not apply, since the outpatient encounter would have already begun (the assessment by the medics)[14] and/or because the ambulance would then reengage operation under the community protocols regarding the care provided and where to take the patient.[8]

Scenario 3. An ED medical director expressed concern when the administration informed its EMS crews that patients who are in hospital-owned ambulances at the scene while waiting for helicopter transport are subject to EMTALA laws as if they were in the hospital's ED. The new policy required the EMS crew to contact the ED physician, obtain agreement that this is a medical emergency, document the contact as a screening exam, and then have the ED arrange transfer as if the patient were in the ED. The medical director questioned the accuracy of the administration's EMTALA interpretation and also noted that inclement weather often dictates placing the patient in the ambulance in the field for medical assessment and/or to prevent environmental exposure while the patient waits for the helicopter.

First, it is true, according to CMS, that if an individual is in a hospital-owned and operated ambulance, that individual has "come to the ED" for purposes of EMTALA. However, as noted in the second scenario, "comes to the ED" is only half of the requirement that must be satisfied before the hospital has a duty to screen or stabilize. The second half is that the patient must request examination or treatment for a medical condition from the hospital. This request can be made by the patient or anyone on behalf of the patient such as EMS, police, family, etc. In this

scenario, though, the patient is not requesting care back at your hospital, but is instead requesting care at the hospital that will receive the helicopter (either at the patient's request or because medical control or the EMS crew believe the other hospital is the most appropriate place to take the patient.) Therefore, under this scenario, the hospital does ***not*** have an EMTALA duty to the patient.

Second, this situation is analogous to use of a hospital's helipad, which CMS agrees does not come under the umbrage of EMTALA.[16] Any patient in a non-hospital-owned ambulance that is on hospital property awaiting use of the hospital's helipad for transport to an appropriate trauma center is deemed to have "come to the ED" because the patient is on hospital property (like the ambulance "hospital property" waiting for the helicopter in scenario 3). However, the hospital does not have a duty to screen or stabilize under EMTALA because the "request" is for use of the helipad, not for examination or treatment of a medical condition by the hospital.[15,17] (Note that if the medics request help from the hospital's ED, such as airway control, then EMTALA is triggered.)

Finally, echoing the ruling in the *Beller* case, if in this scenario the hospital-owned ambulance is operating under community-wide EMS protocols that direct transport of the patient to a different hospital, then the patient is not deemed to have "come to the hospital's ED" and it does *not* have any EMTALA obligations under these circumstances.[8] Consequently, the EMS crew would not have to contact the ED physician, obtain agreement that this is a medical emergency, document the contact as a screening exam, or have the ED arrange transfer as if in the ED.

In summary, whenever a hospital-owned ambulance is operating under established community-wide protocols, CMS does not consider the ambulance to be *"operated by"* the hospital, and, therefore, under its regulations, the ambulance has not "come to the ED," so the hospital does not incur any EMTALA obligations. ■

REFERENCES.

1. 42 CFR 489.24(b)(3).
2. 42 USC 1395dd(a)&(b) and 42 CFR 489.24(a) … assuming the person (or someone on their behalf) is requesting examination or treatment for a medical condition.
3. *Beller v. Health and Hospital Corp. of Marion County*, *Indiana* d/b/a Wishard Memorial Hospital d/b/a Wishard Ambulance Service, No. 11-3691 (7th Cir. Dec. 20, 2012). Note that if a person in a hospital-owned ambulance has 'come to the ED' for purposes of EMTALA, then transporting the person to another hospital would indeed be a 'transfer' as defined by EMTALA - "the movement (including the discharge) of an individual outside a hospital's facilities [in this case the hospital's ambulance] at the direction of any person employed by or affiliated with the hospital." 42 USC § 1395dd(e)(4).
   Also note, the ONLY way to stabilize a pregnant woman with contractions who has an emergency medical condition is to 'deliver the baby and the placenta.' 42 USC 1395dd(e)(3)(A).
4. 42 C.F.R. 489.24(b) (2000).
5. CMS Interpretive Guidelines 1998, pages V23-V24, Tag 407.
6. 42 CFR 489.24(b)(3)(i)&(ii) (2003). Effective date September 9, 2003.
7. *Treadway v. Gateway Chevrolet Oldsmobile Inc.*, 362 F3d 971 (7th Cir. 2004) and *Clay v. Johnson*, 264 F3d 744 (7th Cir. 2001).
8. *Bowen v. Georgetown University Hospital*, 488 U.S. 204 (1988). ("Substantive legislation will not be given retroactive effect unless such be the unequivocal and inflexible import of the statutory terms, and the manifest intention of the legislature.")
9. *Pope v. Shalala*, 998 F.2d 473, 483 (7th Cir. 1993), holding that a regulation "simply clarifying an unsettled or confusing area of the law … does not change the law, but restates what the law according to the agency is and has always been").
10. 68 Fed Reg 53,222 (September 9, 2003).
11. 68 Fed. Reg. 53222, 53224-53225 (September 9, 2003) (emphasis added). "Medicare Program; *Clarifying* Policies Related to the Responsibilities of Medicare-Participating Hospitals in Treating Individuals With Emergency Medical Conditions."
12. This case is distinguishable from two other notable EMS EMTALA cases, *Arrington v. Wong*, 237 F.3d 1066 (9th Cir. 2001), and *Morales v. Sociedad Espanola de Auxilio Mutuo y Beneficencia*, 524 F.3d 54 (1st Cir. 2008), in which a federal court did impose EMTALA liability on the hospital. In *Beller*, the ambulance was owned by the hospital but operating under community-wide EMS protocols; in both *Arrington* and *Morales,* the ambulance was not hospital-owned, the ambulance was not being directed by EMS protocols, and the hospitals were not on diversion status at the time they rerouted the ambulances to other hospitals.
13. 42 CFR 489.24(b).
14. CMS State Operations Manual (SOM), Appendix V – Interpretive Guidelines – Responsibilities of Medicare Participating Hospitals in Emergency Cases – EMTALA, Revision 60, Effective July 16, 2010. Available at: http://www.cms.gov/manuals/downloads/som107ap_v_emerg.pdf
15. 42 USC 1395dd(a); 42 CFR 489.24(a).

No Specialist Available? Protect Yourself Legally

Not surprisingly, if a consultant is unavailable and a bad outcome occurs, the emergency physician (EP) is potentially a defendant in any subsequent medical malpractice lawsuit, says **Damian D. Capozzola**, JD, an attorney with Crowell & Moring, LLP, in Los Angeles, CA. "If an outcome goes bad, you can't stop somebody from paying the filing fee, filing a complaint, and initiating a lawsuit naming essentially every provider who interacted with that patient concerning the problem leading to the bad outcome," he says.

Capozzola says that the main factor determining whether such a lawsuit would actually succeed, however, is whether the EP acted "reasonably, under the totality of the circumstances that existed as of the time the patient presented to the ED."

The EP should consider carefully documenting his or her familiarity with, and compliance with, the facility protocol for contacting on-call physicians, which may require a number of escalating steps in the event the scheduled on-call physician is unavailable, advises Capozzola. "The EP should also consider, and document, ordering additional tests and evaluating results from the perspective of the missing on-call physician if he or she remains unavailable," he adds.

If the ED patient is presenting with circumstances requiring decisions immediately in areas where the consultant would have been valuable, but the consultant is not there, Capozzola says the EP simply needs to act as he or she deems best for the patient. This might involve a transfer to a different facility.

"At least one reported opinion illustrates an EP apparently escaping liability in large part because a transfer was ordered in the absence of a qualified on-call physician with privileges at the facility," he notes.[1]

Capozzola acknowledges that it is generally the on-call physician's duty to reasonably notify a hospital that he or she will not be able to fulfill the on-call duties. However, in an emergency scenario with an unstable and/or declining patient, failing to act and allowing the patient's symptoms to worsen while trying to track down a wayward consultant could expose the EP and the facility to liability.

"But where the patient can be stabilized, and there is no material risk of a problem worsening while the consultant — or another consultant — is located, then it is riskier for the EP to stick his or her neck out and take charge in what may not be an area of relative expertise," he says. "If the patient is stable, there's little reason not to wait for a specialist to consult."

On-call Refusals

Stephen A. Frew, JD, vice president of risk consulting at Johnson Insurance Services and a Rockford, IL-based attorney, says that the *reason* for transfer is often the legal basis for lawsuits involving transfer to another facility.

"These cases often involve refusal of the on-call physician to come in to see the patient, and the decision of the EP to transfer the patient without challenging the refusal through the hospital chain of command or securing alternate coverage for the necessary specialist," he says.

In one such case, a motor vehicle accident patient presented by ambulance to a rural ED, where a resident diagnosed a vascular surgical condition and arranged transfer. "The helicopter arrived, but in the meantime, the first hospital cancelled acceptance and the other hospital's on-call refused the patient," says Frew. "The resident requested the on-call surgeon to come in and help stabilize the patient while he searched for an accepting hospital, but the on-call refused to get involved." More than four hours later, an accepting physician was located and the patient was transferred, but the patient died during surgery.

"The on-call surgeon at the initial hospital was cited, along with the other hospitals and their on-calls," says Frew. "There was a massive undisclosed settlement."

Did the on-call specialist refuse to come to the ED or fail to respond to call, as opposed to legitimately being unavailable in surgery or because of circumstances beyond his or her control?

If so, says Frew, the EP "has an affirmative duty under [the Emergency Medical Treatment and Labor Act] to list the name and address of the refusing or non-responding physician in the transfer documentation." ■

REFERENCE

1. Brown v. Bailey, 210 S.W.3d 397 (Mo. App., 2006)

Sources

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Mitigate Legal Risks of ED "Bounce Backs"

Don't make dangerous assumptions

Lab work was ordered for a patient who presented to an ED after having experienced her first seizure, but it wasn't reviewed until *after* the patient was discharged.

Later that same day, the patient was brought back to the ED after a second seizure, at which time no one checked the results of the prior lab work. New lab work was ordered after an intravenous line was inserted and a half normal saline drip started.

"The patient was taken for a radiographic study, during which she suffered irreparable brain damage due to untreated hyponatremia," says **Robert J. Conroy**, JD, an attorney at Kern Augustine Conroy & Schoppman in Bridgewater, NJ. "Subsequent review revealed that both labs reflected the patient's abnormally low serum sodium levels. The patient died, and there was a substantial settlement."

If the EP had simply reviewed the chart and the earlier lab reports, this quickly would have revealed that the patient was hyponatremic, and might have permitted a timely treatment to reverse the patient's course, says Conroy.

For recently discharged ED patients, Conroy says that "the number one problem from a liability perspective occurs when no one, including the EP, follows up on what occurred during the previous ED visit."

The EP should never assume that a prior workup was followed up on, or that studies ordered previously were reported or read, adds Conroy.

"If something happens later on, it gives the patient a chance to say, 'This was a second or third chance for the EP to make this diagnosis,'" says **Michelle M. Garzon**, JD, a health care attorney at Williams Kastner in Tacoma, WA. "The EP's culpability is stronger on each subsequent readmission."

EPs should consider these risk-reducing strategies if a patient has recently been evaluated in the ED:

• Gather information about the prior ED evaluation.

"This means going beyond just asking the patient what happened during that visit," says **Roger J. Lewis**, MD, PhD, FACEP, a professor in the Department of Emergency Medicine at Harbor — UCLA Medical Center in Torrance, CA. "You are already in a situation in which the prior visit appears to have failed to completely address the patient's medical complaint."

This might involve a thorough review of information within your own hospital's information system or requesting information from another ED at which the patient was seen, with appropriate permissions, says Lewis. "Document the information about the prior visit and the fact that you have reviewed that information," he says.

• Don't assume that a prior diagnosis or treatment plan was correct or appropriate.

During your own assessment and the development of a management plan for the patient, Lewis says to avoid the cognitive error of premature closure, in which the diagnoses reached during the prior evaluation are the only ones considered in the current evaluation.

"Given that the patient has re-presented to the ED, the patient deserves — and it is in everybody's best interest — for the current physician to carefully consider the possibility that the prior diagnoses were either correct, incomplete, or incorrect," says Lewis.

Garzon says that she has seen plaintiffs testify that the EP didn't take them seriously because they come to the ED often. "That's an accusation that plaintiff lawyers like to be able to lodge," she says. "EPs should be careful to keep bias out of their decision-making. It is good to keep that top of mind."

• Regardless of your opinion, avoid any appearance of criticizing the prior evaluation.

Criticizing the prior evaluation doesn't do the patient any good, and, if there is a bad outcome, it certainly doesn't protect the EP in any way, according to Lewis. "Also, it's not really intellec-

tually honest," he says. "You weren't there at the time those treatment decisions were made. There is no way you can know for certain whether they made sense in the clinical context at the time."

If a patient believes the previous EP made a mistake, Lewis recommends stating, "I'm not in a position to know whether that's true or not, but what I can do is address your symptoms today." "Focus both the patient and your evaluation on their current medical condition, not on criticizing earlier care," he says.

If the EP criticizes the initial EP for an inadequate assessment, the initial EP is likely to respond in kind. "Criticizing each other in the medical record makes it extremely easy for physicians to be pitted against each other during any subsequent legal action," says Lewis.

If something was overlooked during a visit that occurred in the same ED, such as a fracture missed on an X-ray, Garzon says the EP should consider mentioning it to the initial EP informally.

"Do this just as an education and heads-up that this was a near miss," she advises. "Many people would appreciate that feedback, but I would not document anything in the chart." ■

Was ED Patient Recently Hospitalized? Reduce Risks

Contact prior physician

Forty percent of hospital readmissions within 30 days come through the ED, according to an analysis of data from the Healthcare Cost and Utilization Project state inpatient and ED databases on 4,028,555 patients discharged from acute care hospitals in California, Florida, and Nebraska between July 1, 2008, and September 31, 2009.[1]

Jesse M. Pines, MD, MBA, MSCE, one of the study's authors and an associate professor in the Departments of Emergency Medicine and Health Policy at George Washington University in Washington, DC, says that as a practicing EP, he was not particularly surprised by the findings.

"We often see patients soon after discharge from the hospital, and many times, are able to discharge the patient home," he says. "What is surprising is that so much focus of the health policy discussion has been on 30-day readmissions, and there has been so little discussion on 30-day treat-and-release ED encounters."

Both scenarios can mean that something might have gone wrong during the hospital discharge process, such as poor care coordination while the patient was in the hospital, an imperfect discharge plan, or a poor transition of care, says Pines.

Return encounters are a good starting point for EDs developing quality assurance and improvement programs, according to Pines. "Reviewing charts of 'bounce backs' can sometimes uncover systematic problems that need to be addressed to limit liability risk," he says.

EP Needs Information

It's very problematic when an EP tries to assess a recently hospitalized patient without detailed knowledge of what went on during that hospitalization, says **Roger J. Lewis**, MD, PhD, FACEP, a professor in the Department of Emergency Medicine at Harbor — UCLA Medical Center in Torrance, CA. "Especially given the advent of electronic medical records, it's easier to access that information, so there is no excuse not to have it," he says.

It is critically important that the EP assess whether the course of the patient's post-discharge recovery matches what was expected — for example, the amount of post-surgical pain a patient has, says Lewis.

"Although the evidence is that most of these visits will be related to the hospitalization, there is always the chance that the patient is presenting with a new acute medical condition, so one wants to avoid premature closure," he explains.

Contact Prior Physician

Did the EP document a discussion with the attending physician for the patient's recent hospitalization regarding the patient's ED visit and the differential diagnoses being considered? This can be deciding factor in whether the EP is dismissed from a medical malpractice suit, says **Michelle M. Garzon**, JD, a health care attorney at Williams Kastner in Tacoma, WA.

"Good documentation of what they discussed, what their recommendations were, and that these were conveyed to the patient, can go a long way to defending the EP," emphasizes Garzon.

Garzon is currently handling a claim involving a patient who was discharged after abdominal surgery and presented to an ED a few days later with a suspected ileus. "The EP contacted the surgeon, who agreed with the EP's findings, and gave instructions for the patient to see him the following day," she says. "There was a bad outcome, and both doctors were sued."

The EP's documentation of this discussion will be very helpful in the EP's defense, according to Garzon, adding that she believes many such phone consults *aren't* documented by EPs. "The EP is then in the position of saying, two or three years later, 'It's my practice to call, but I can't remember,'" she says.

EPs are sometimes reluctant to bring another provider into the medical record, says Garzon, "but if it happened and it's accurate, you can document very factually and not be throwing somebody under the bus." ■

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Does Accessing Database Help or Hurt EPs Legally?

Info could come up during litigation

If an emergency physician (EP) decided *not* to prescribe opioids for a patient after learning from a prescription drug monitoring database that the patient had just received a two-week prescription for the same medication from another provider, could the EP be successfully sued for failure to treat? Or would the EP be more likely to be sued if narcotics were prescribed anyway and the patient overdosed?

"EPs are concerned that they will be sued for failing to provide care if they *do* consult the database and decide not to prescribe. On the flip side, will they be sued if they choose *not* to access the database and it turns out there was abuse?" says **Tara Adams Ragone**, JD, a research fellow at the Center for Health & Pharmaceutical Law & Policy at Seton Hall University School of Law in Newark, NJ. "It cuts both ways, and it's certainly a difficult judgment call."

Many states provide immunity for reporting information to and/or using information obtained from prescription drug monitoring databases in good faith, though language and scope vary, notes Ragone.

"We are not yet seeing how fully this might be used against doctors. That is part of the liability puzzle that remains unsolved," says Ragone. "I am not seeing evidence that EPs are successfully being held liable for failing to access databases, but we may see people testing and pushing."

Prescribe "With Great Care"

Wrongful death cases involving narcotics prescribing are becoming more common, warns **Jennifer L'Hommedieu Stankus,** MD, JD, an EP with Team Health Northwest Emergency Physicians in Tacoma, WA, and former medical malpractice defense attorney.

"This is a growing area of liability, and plaintiff attorneys are catching on," says Stankus. "Therefore, EPs must write for prescriptions for narcotics with great care." TeamHealth Northwest's ED's policy that there will be no refills for narcotics, and that chronic pain will not be treated, is clearly posted in the waiting room.

"Further, we track how much narcotic is being

prescribed, on average, by each physician in our group, and discuss this at our monthly meetings," says Stankus. "We give short-term prescriptions and referrals to a primary care physician. This has dramatically cut down on the number of people presenting with drug-seeking behavior."

EPs should never write for more than a few days of narcotics, and even then, should counsel the patient on the dangers of narcotics and the importance of only taking the amount prescribed and document this, advises Stankus.

Whether or not the EP accessed a prescription monitoring database could become a key issue during litigation involving a patient's overdose, says Ragone. "What the EP did to assess whether the patient was obtaining drugs from multiple sources will certainly be relevant in an analysis of liability in an overdose situation," she says. "It could also be relevant in terms of determining whether or not the EP appropriately prescribed."

Ragone offers these risk-reducing strategies for EPs:

• EPs should know their state's requirements as to whether they must consult a prescription monitoring program database before prescribing.

"If this is optional, EPs should consider the value that this information can add to their ability to make treatment decisions," says Ragone. EPs might decide to prescribe for fewer days, or decide to contact the patient's treating physician, for instance.

• EPs should document that clear instructions were given to the patient on the potential for abuse and the dangers of mixing the medications or taking more than the appropriate dosage.

• EPs should be aware of current guidelines on emergency department prescribing.

For instance, the New York City Department of Health and Mental Hygiene issued guidelines in January 2013 for opioid analgesic prescribing to patients being discharged from the ED. (To view the guidelines, go to: http://on.nyc.gov/YZVuhf.)

While guidelines such as these don't establish the standard of care, says Ragone, "they are part of the landscape doctors should consider in determining what the standard of care requires. The plaintiff's expert might agree that they are consistent with the standard of care."

EPs should consult these guidelines and determine the extent to which they may embody current consensus on the standard of care, advises Ragone. "They should assess the degree to which they can deviate from these voluntary standards without deviating from the standard of care," she says.

• EPs should document their medical decision-making.

The EP's best defense is to show that the best medical judgment was made using the information available to them, according to Ragone.

"If you accessed the database, show what you did with the information," she says. "Did you give a shorter dose that will get the patient through the weekend and permit follow-up with a primary care physician, for example? Or did you prescribe, despite red flags, because the patient was in so much pain?"

Failure to Treat

Information accessed through a prescription monitoring database can help EPs to document their rationale if they decide *not* to prescribe after performing a medical evaluation fully consistent with the standard of care, says Ragone.

"This can support them in saying, 'Not only am I not finding evidence of a medical condition to treat after a thorough work-up, but I also have good reason to suspect diversion or abuse,'" she says. "Documenting your rationale is critical if someone comes back and alleges that you failed to treat a condition."

Failure to treat a patient's pain is a serious legal risk for EPs, if they do not treat a patient with severe pain because they believe the patient is a drug-seeker, warns **Robert Dunne**, MD, FACEP, vice chief of emergency medicine at St. John Hospital and Medical Center in Detroit, MI.

"Probably the biggest risk is if you see a patient who describes severe pain and you do not treat them because you think they may be a 'drug seeker' — and they turn out to have multiple myeloma or cancer or something similar," he says.

Dunne cautions that the mere fact that an ED patient has received narcotics previously is not, in itself, a reason to deny treatment. "There are many factors to consider. The patient may have had an acute injury," he says. "You are always better off taking the patient at face value."

Dunne says that if he suspects a patient is drug-seeking, he looks at prior medical and prescription records and performs a thorough examination and history.

If a patient has a chronic pain problem, Dunne asks which provider manages it and attempts to contact that person. "Many times, the doctor has been able to tell me that there is, or is not, a problem," he says. "Often, they will see the patient the next day, so there is no need to provide a prescription in the ED."

Knox H. Todd, MD, MPH, chair of the Department of Emergency Medicine at MD Anderson Cancer Center in Houston, says that "prescribing without an adequate assessment — and this might eventually mean routine querying of online prescription monitoring programs — would seem to me a red flag."

To protect themselves legally, Todd says that EPs should document the nature of the patient's pain thoroughly, should not prescribe long-acting opioids, and should prescribe only quantities sufficient to allow the patient to seek care from a continuity care provider.

"Document yellow or red flags that might indicate a higher or lower risk of prescription opioid abuse, including use of state prescription monitoring programs when available," he advises. ■

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 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. ■

CNE/CME QUESTIONS

1. Which is true regarding an emergency physician's (EP) legal obligations when a consultant is unavailable?
   A. The EP is expected to act reasonably under the totality of the circumstances that existed as of the time the patient presented to the ED.
   B. Failing to act and allowing an unstable patient's symptoms to worsen cannot expose the EP to liability as long as the EP is attempting to contact the consultant.
   C. The EP has a duty under the Emergency Medical Treatment and Labor Act (EMTALA) to list the names and addresses of on-call specialists who fail to respond to call, even if the consultant is legitimately unavailable because of circumstances beyond his or her control.
   D. If the on-call specialist refuses to come to the ED, the EP has an affirmative duty under EMTALA to list the physician's name and address in the transfer documentation only if the patient's condition is emergent.

2. Which of the following statements is *true* regarding the legal risks for an EP seeing a patient who was recently evaluated in the ED?
   A. EPs have no legal obligation to determine whether the prior workup was followed up on or if studies ordered previously were reported or read.
   B. It is not advisable for EPs to document information about the prior visit.
   C. EPs should carefully consider the possibility that prior diagnoses were either correct, incomplete, or incorrect.
   D. EPs should clearly document their disagreement with a prior treatment plan or diagnosis in the medical record.

3. Which is *true* regarding EPs accessing a prescription drug monitoring database, according to **Tara Adams Ragone**, JD?
   A. Any information obtained by the EP would not be admissible in court.
   B. No states currently require physicians to access databases before prescribing narcotics.
   C. Whether or not the EP accessed a database would not be relevant to determining if the EP prescribed appropriately under any circumstances.
   D. What the EP did to assess whether the patient was obtaining drugs from multiple sources would be relevant in an analysis of liability if a patient overdosed.