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

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Courts continue to limit COBRA liability for prehospital destination decisions

By **Catherine Harris**

The family of a Honolulu man who died after his ambulance was rerouted from one hospital to another facility does not have grounds to sue under EMTALA because the patient never physically presented to the first hospital's emergency department (ED), states a recent Hawaii district court ruling.

According to court documents in the case of *Arrington v. Wong*, 59-year-old Harold Arrington was on his way to work when he began to have trouble breathing. An ambulance was called to the scene, and paramedics found Arrington in "severe respiratory distress." The decision was made to transport him to Honolulu's Queen's Medical Center. En route, the paramedics sought medical advice from the emergency room physician at Queen's. During the conversation, paramedics mentioned that Arrington was a "Tripler patient," meaning he was a patient at a nearby hosptial. The emergency physician then advised paramedics that, "if you start with nitro and oblasics, then I think it would be OK to go [to the other hospital]." The patient was taken to the other facility, where he "coded" and was unable to be revived.

His family sued Queen's, the emergency room physician, the physician's medical group, the city and county-owned ambulance service, and the attending emergency medical technicians under EMTALA.

This federal law requires hospitals to provide an appropriate medical screening examination sufficient to rule out an emergency medical condition to any patient who "comes to" the hosptal's ED. Furthermore, EMTALA requires hospital personnel to ensure that any emergent condition of any patient who has "come to" the hospital be stabilized before transfer to another facility.

Arrington did not meet the definition of "coming to" the hospital even though he was in an ambulance that was on its way to the hospital, and, therefore, his family could not sue on EMTALA grounds, the court found.

Ruling Reinforces Prior Decision

There has already been a landmark legal decision in this area, and the Arrington case just strengthens that decision, states **Robert Bitterman, MD, JD,** Director of Risk Management and Managed Care in the Department of Emergency Medicine at Carolinas Medical Center in Charlotte, NC.

In a 1992 case, *Johnson v. University of Chicago*, a mother sued the local hospital that operated a service directing ambulances to various area hospitals after they directed the ambulance carrying her daughter to a hospital more distant than the others, where the girl died.

The case is unusual in that the U.S. Court of Appeals for the Seventh Circuit first ruled against the hospital, then reversed itself, ruling that, because the girl had not actually been physically present in the hospital, the case did not meet the standard to sue under EMTALA, says Bitterman.

The U.S. Court of Appeals for the Ninth Circuit, which covers Hawaii, has not addressed this question of law, but the district court cited the Seventh Circuit's decision in its ruling.

"The Seventh Circuit upheld the dismissal of the EMTALA claim because of its conclusion that, under the plain meaning of the statute, the child never 'came to' the emergency department," the decision states.[1]

In its ruling, the district court also cited a 1994 ruling from the Fifth Circuit, in *Miller v. Medical Center of Southwest Louisiana*, which found that a patient was denied admittance to the hospital over the phone but never presented to the emergency room in question. The appeals court for that circuit also ruled that the plaintiff had not met the standard for "coming to" the emergency department.

EMTALA Not Intended to Cover Medical Decisions

The decision in this case is encouraging because it continues to show that the courts are willing to limit EMTALA liability to cases that concern a diversion of patients due to financial concerns, says **James Augustine, MD, FACEP,** Chief Executive Officer of Premier Health Care Services, an emergency medical practice group based in Dayton, OH.

"EMTALA was intended to prevent hospitals from sending out indigent patients to other hospitals," he emphasizes. "These cases are not patient-dumping issues. It gets into local protocols for medical direction."

For example, it is legitimate for a hospital to go on "ambulance bypass," refusing to receive patients by ambulance when they believe they are too busy to care for them properly. It is also common for an ambulance under the medical supervision of one hospital's ED to pick up a patient who requests to be taken to the hospital where he normally receives medical care, he explains.

"In those cases, the paramedics will communicate by telephone with the [ED] physician, get the OK to go [to the other facility], and get instructions about medications and care," he notes. "It is appropriate medical practice."

The plaintiff's bar has shown an inclination to take cases to court under EMTALA and attempt to stretch its protections far beyond what Congress originally intended, he contends.

There have been cases where a person has filed an EMTALA claim after they were treated in the ED, admitted to the same hospital, moved upstairs to an inpatient bed, then had a poor outcome, he says. "They file a claim saying that the patient was not properly stabilized in the ED and that's a violation of COBRA."

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Impact on EMS and Managed Care

Rulings in this area may have a substantial impact on the move by many medical groups to integrate transportation services into their group practices.

Ideally, through these integrated arrangements, an ambulance could pick up a patient, evaluate his or her condition (using medical guidance from supervising emergency room providers), then either take them to the ED, treat them at the scene, or redirect the patient to a lower level of care.

If managed correctly, these arrangements could save health plans and health providers thousands, while improving patient care at the same time, Augustine notes.

Premier is working on establishing such a system in the Dayton area.

Many health plans, including those administered by the federal government, already attempt to direct patients to certain medical facilities and levels of care, Augustine notes.

For example, in the Dayton area there is a Veterans Administration hospital. In many cases, ambulances will pick up a veteran who requests to go to the VA facility.

"They have had it drilled into them that they are supposed to go to that hospital for their wound care, for everything else," Augustine says. "They get very upset if you just bring them to the nearest hospital."

It should be up to the medical community to ensure ways of getting patients to the medical facilities that provide care covered by their health plans, yet do so in a safe and medically accepted manner, he states. ■

Reference

1. *Arrington v. Wong, D.* Haw. 98-00357 DAE 9/23/98.

Reduce legal risks of complaints

ED managers can do a lot to reduce liability risks presented by patient complaints, says **Michelle Regan-Donovan, RN, BSN, CEN,** principal of Millennium Strategies, based in Charlottesville, VA and Ambulatory Care Advisory Group, based in Chicago, IL. "A comprehensive complaint management system for most ED's is highly time and resource consumptive. However, if complaints are well managed, that may ward off any number of liability concerns," says Regan-Donovan.

If a patient's complaint is not properly managed, the patient may report the

problem to other bodies, such as the Office of Quality Monitoring at the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) or their state Peer Review Organization, warns **Sue Dill Calloway, RN, MSN, JD,** director of risk management for the Ohio Hospital Association in Columbus.

"Many organizations now post toll-free numbers for patients to voice any concerns or comments," notes Dill Calloway. "Hospitals in our state have recently seen a significant increase in the past year of unannounced surveys by HCFA [Health Care Financing Administration], which occurred after the patient lodged a complaint," she reports.

Hospitals have also had visits from the Office of the Inspector General when patients lodge complaints of fraud and abuse, notes Dill Calloway. "Articles covered in the newspaper could have a negative effect on the hospital and compromise patient trust in the facility," she says.

Here are ways to reduce legal risks posed by complaints:

Listen to patients. Proper handling of patient complaints can reduce or prevent lawsuits, says Dill Calloway. "Patients who are disgruntled often file lawsuits. When I defended nurses and physicians who had been named in medical malpractice lawsuits, we were able to settle about 78% of all the claims for this company without one penny of payment," she reports. "These were considered to be nonmeritorous claims."

However, in taking the depositions of these plaintiffs, it became clear why the suits were filed, says Dill Calloway. "Patients usually filed the lawsuits because they had complaints that fell on deaf ears," she explains. "Simply listening to the patient's concern and complaints may have been all that would have been needed to deter a lawsuit."

Keep a paper trail. Legal counsel should be pursued after meetings of the medical director, nursing director and hospital administration, or as a direct result of an alleged lawsuit or maloccurence, Regan-Donovan notes. "A paper trail of some sort (even if only a file) is recommended to show that indeed there is a system for tracking and following up on

various types of patient complaints," she says.

Know which complaints to refer to risk management. "Any allegation which meets the JCAHO's definition of [a] sentinel event should be reported, because the facility only has 45 days to complete a thorough and credible root cause analysis," says Dill Calloway. "Also, any complaints alleging serious criminal activity, fraud and abuse, potential litigation, or violations of federal or state statutes and regulations should all be reported to risk management."

Risk managers should always be advised of any threat (formal or telephoned) that intimates lawsuit, misdiagnosis, or bad outcome, as soon as possible, stresses Regan-Donovan. "A short memo to the directors (medical, nursing) and the director of the department is sufficient," she says. "This should not negate the return call to the patient, however, since much crisis intervention might be achieved with the phone call and empathetic conversation."

Don't acknowledge error. "Written or phone responses to a complaint should always be documented, and admission of error or libel never acknowledged to the complainant until legal counsel is notified, even if it is known to be true," stresses Regan-Donovan.

Always indicate that the management team will be doing everything in their power to correct the situation, without suggesting or promising any disciplinary action or an ongoing problem, Regan-Donovan says. "Instead, thank them for identifying a very important issue, and suggest that you will be addressing this with others as appropriate," she advises. ■

Know responsibilities for patients outside the ED

By **Staci Bonner**

Chicago-based Ravenswood Hospital made national headlines in 1998 after a tragic death from a gunshot wound occurred in close proximity to the doors of the ED. According to news reports, a 15-year-old boy was brought within yards of the ED after being shot while playing basketball. Hospital policy prohibited ED staff from leaving the department. When an ambulance failed to arrive in a timely manner, police brought the boy inside the ED, but he died shortly afterward.

The incident, reported by major news organizations, led to an HCFA investigation, and resulted in an announcement by President William Clinton, who threatened to withhold Medicair payments from any hospital that fails to provide emergency care. Within 48 hours, the hospital revised its policy, but rumors continued to fly.

"There were myriad misconceptions about what actually happened," says **Susan Nedza, MD, FACEP**, immediate past present of the Illinois College of Emergency Physicians and an attending physician at Christ Hospital in Oak Lawn, IL. "After the initial furor died down, it became apparent that the ED was full and the physicians were occupied, and that certain people involved may not have even been ED employees."

Still, considerable damage was done to the hospital's image in the community. "The hospital rectified the situation before any investigation was ever started. But regardless of that, if there is a bad relationship between a hospital and the community it serves, it can be pretty devastating," says Nedza. "The consequences were so bad that even the President commented on what he felt needed to be done."

ED managers are paying a lot of attention to the incident, which has captured the public's attention. "It has increased the dialogue between legal and administrative staff at any number of hospitals," Nedza says. "This was a warning shot. If it happens again, the negative repercussions are likely to be even greater."

Use common sense

When evaluating your hospital policy, there are several issues to consider, stresses **Nancy Auer, MD, FACEP**, current president of ACEP and director of emergency services at Swedish Medical Center in Seattle, WA. "You need to be concerned about the protection and safety of your own staff," she urges. "Also, if you abandon your own ED, do you have enough personnel to care for patients left in the department?"

ED staff may not be prepared to contend with emergencies outside the department, Auer says. "I don't know of any ED that has a $125,000 first-aid kit that we take with us like the 911 system does," she notes. "They are prepared and trained to take care of out-of-hospital emergencies, but we are not."

Policies must be flexible, says **Tallien Perry, JD**, a

Los Angeles-based healthcare attorney. "Having a black and white policy will be extraordinarily difficult," she explains. "The best you as an ED manager can hope for is that people will use their best judgment."

On one occasion, a patient who had been shot 17 times drove himself to the hospital but was unable to make it inside the facility, Dill Calloway recalls. "The ED staff got a cart and took him to the trauma room," she says.

However, other situations may be outside the scope of ED staff's expertise. "If the street is 15 feet outside the ED and victims are trapped inside [a vehicle], the appropriate action is to call 911. EDs don't have the jaws of life or extrication equipment and haven't been trained in that," says Dill Calloway. "Staff should not do anything beyond their scope of practice. You just have to use good common sense."

Some situations are best suited for prehospital responders, says Dill Calloway. "While anybody can render comfort and emotional support, you may not have the necessary technical or medical expertise, whereas EMTs and paramedics are taught how to respond in the absence of a sophisticated medical facility around them," she explains.

If there is a malpractice suit stemming from a clinician's failure to leave the ED to care for a patient, the outcome depends on several factors. "That is proven in the courtroom by evidence such as expert testimony, violation of a state or federal law, policies and procedures, and even the position statement issued by the AHA. All of that may be introduced into evidence in most states and considered by the jury," says Dill Calloway.

The safest thing is to do whatever is reasonable and best for the patient, says Dill Calloway. "For example, if someone drops off a patient with a gunshot wound right outside the ED, consider what a reasonable and prudent physician or nurse would do," she says. "This is the legal standard by which you will be judged in the courtroom."

Review existing policies

Many hospitals currently have policies that require staff to dial 911 to care for patients outside the ED, says Perry. "When 911 responds, they take the patient to the most appropriate hospital. That may not always be the nearest hospital, even if it's 20 feet away," she explains.

The Ravenswood incident was a major red flag, causing ED managers and hospital administrators nationwide to review existing policies. "We had a quality improvement meeting for the Ohio Hospital Association in response to the incident," reports Dill Calloway.

Representatives from 40 hospitals were in attendance, and half of the group had a policy pertaining to hospital employees leaving the facility to care for patients. "Of the hospitals that had an existing policy, all had pulled it out to review it after the incident," Dill Calloway reports.

When reviewing hospital policies regarding staff caring for patients outside the ED, consider these

AHA issues recommendations

The American Hospital Association issued guidelines that hospitals should use to review their policies. Here is partial content of the guidelines:

- Make sure you know what your hospital's ED policy is on sending staff outside the ED and off-hospital premises to deliver care. Review the policy to determine if it allows flexibility for staff to use their best judgment. Remember that federal regulations require that a hospital must screen all patients on hospital property who request care to determine whether they have an emergency medical condition. Those who do must be stabilized or appropriately transferred. These requirements apply to all settings on the hospital campus (i.e., ambulatory surgery areas, physician offices), not just the ED.
- Educate your ED staff on your policy. Determine when the last training session was for ED staff and consider a "refresher" course for them. It's especially important to train and educate any contract workers you may employ in key areas. Make sure your communications, security, and any other appropriate departments are aware of that policy.
- This case has raised many quality and public perception issues. Consider touching base with local community leaders and the media to reassure them about your policies, procedures, and commitment to patients.
- Regardless of what your policy is, this is a good time to reconnect with your community ED response agencies such as the rescue squad and police and fire departments. Ensuring coordination and understanding of each entity's responsibilities goes a long way to avoiding misunderstanding if such incidents arise. ■

options:

Avoid prohibiting staff from leaving the ED. "Don't put it in black and white that the staff can't leave under any circumstances," advises Dill Calloway. "If optimal care can be rendered immediately, it should be. Certainly, there are cervical collars in the ED, so if somebody hurt their neck, ED staff can assist them. You need to give staff members reasonable discretion."

There are no hard and fast rules, says Dill Calloway. "Basically, it is very difficult to write a rigid black and white policy," she stresses. "In general, no one should be asked to perform beyond their capability. Before leaving the ED, ask yourself, do you actually have the capability, training, and skills to be able to do anything?"

Make sure staff understands the hospital's policy. "One of the most common causes of allegations against hospitals is failure to be aware of, or to follow, your hospital's own policy," says Dill Calloway. "That can be used as evidence against you in a courtroom. It's impossible to know all the hospital policies and procedures, yet staff are legally bound to have a knowledge of what is in there."

Since the issue is making headlines, it's smart to familiarize ED staff with the hospital policy on leaving the ED. "Instead of just putting it in the manual and forgetting about it, put a copy in everybody's mail box, bring it up at a staff meeting, or post it with a place for staff to sign their initials to indicate that they have read that communication," Dill Calloway suggests.

Know EMTALA regulations. The incident has raised awareness about responsibilities under EMTALA. "Many administrators were unclear as to what the 'come to the hospital' provision means," says Nedza. "If anyone presents on facility grounds with an emergency medical condition, you need to have a plan in place to take care of them."

Realize that EMTALA also applies to patients outside the ED, as long as they are on hospital grounds. "As of July 1994, the regulations state that EMTALA applies to anyone on hospital premises, not just in the ED," Dill Calloway emphasizes.

Assess malpractice coverage for patients outside the ED. Before revising policies, physician groups should check with their malpractice carrier to make sure they are covered for those services, says Perry. "Policies and state law differ on this, so that is something to look at," she says.

Consider safety of ED staff. "Any response has to take into account the safety of the person responding," says Dill Calloway. "It's not appropriate for a nurse or physician to walk into the middle of a gun battle. It won't do any good to send a clinician out to rescue someone when they themselves are likely to get injured."

Safety of ED staff must be considered, emphasizes **Larry Bedard, MD, FACEP**, director of emergency services at Doctors Medical Center, San Pablo and Pinole Campuses, CA. "If physicians run to pick up a gunshot victim, they could be putting themselves in physical danger, unless police are there to secure the scene, " he says. "Most physicians would be apprehensive in that situation. It could be a gang-related killing, with people waiting with weapons to see if another gang member will respond. Those are legitimate concerns."

Consider patients within the ED. "If you have critical patients in the ED, you would not want to deplete the ED to go outside and care for other patients," says Dill Calloway. "You need to take into consideration the safety of patients in the ED. Are you sure that the people being left behind are not being compromised? If it's a rural hospital and there is one nurse and one physician on duty, and you have a critical patient in the ED, you can't just run out and leave."

Doing so would expose physicians to legal risks, stresses Bedard. "Most emergency physicians will respond to inpatient codes. But, if someone came to the ED and ruptured an abdominal aneurysm because you ran out to help someone in the parking lot, I think you could be held liable," he says.

Although there are also potential legal risks involved, in most states, physicians who give emergency care outside the ED have immunity under good Samaritan laws. "The question is whether the physician is voluntarily going to render care because he or she is a physician, as opposed to acting on behalf of the ED in his or her scope of employment," says Perry.

If there are patients in the ED who would be left untreated, the situation is more complicated. "If the ED is full and you are in the middle of treating patients, you have a more difficult argument for going outside," says Perry.

Make the ED the priority. Guidelines must have flexibility but should stipulate that the staff's primary responsibility is to patients in the ED. "That way,

if an incident occurs and someone asks, 'why didn't you go help them?,' you can respond that you had patients in the ED and that hospital guidelines state that they are your first priority," says Auer. "You can explain that you didn't feel you could safely leave to go out and render aid, or you didn't have the resources to go out and take care of a gunshot wound."

Know EMS response times. Response times should be factored in when making decisions about whether to leave the ED. "We have office buildings on our campus that are four blocks away. Obviously, we can't have people running from here all the way over there, so we recommend that 911 be called in case of emergency," says Auer. "We have a medic unit located nine blocks from us, and another within a mile, so we are well served by our local EMS."

Address role of in-house code team. "Security are first responders here, and everybody is told that when they call in an incident, they need to give information about the severity of the patient's condition, location, and what help is needed," says Auer. "Then, the operator can trigger the code team to respond."

The next step depends on the severity of the patient's condition. "If an elderly person is just sitting down because they are tired, they may be helped to their car in a wheelchair," notes Auer. "But, if somebody is truly ill or has arrested, they can be transported to the ED by the code team, or the team can work on them wherever they are. If they are stabilized, they may go directly to the ICU."

Federal legislation proposed

Federal legislation HR3937 has been introduced by Rep. Bobby Rush, D-IL, in response to the incident. The legislation would amend Title XVIII of the Social Security Act and bar hospitals from putting limits on ED staff treating patients in the immediate vicinity of the department entrance.

The proposed legislation has created controversy in the emergency medical community. "To take a single incident and blow it up into a national precedent is a poor way to make public policy," says Bedard. "It was clearly done for political reasons without an understanding of healthcare issues."

The proposed legislation stipulates that a hospital employee must respond to a patient within 150 feet of the hospital. "The 150 feet standard is pretty irrational," says Bedard. "When ACEP's government affairs committee discussed the proposed legislation on a conference call, one physician indicated there is a tattoo parlor within 150 feet of his ED. Does that mean if somebody faints, we've got to run over from the ED?"

The legislation presents several problems, says Auer. "What if a patient is 150-feet and one inch from the ED? Or, if a nursing home is located within 150 feet of ED, do we have to go there every time somebody falls out of bed?" she asks. "There need to be guidelines and principles in place that help personnel keep their mission, but that define their primary responsibility to their own ED, patients and personal safety."

Distance should not be the only factor used to make the decision to go outside and give care, says Auer. "If everybody is sitting around with no patients, and somebody falls on the sidewalk, it may be quite appropriate to go and help that person," she says. "However, if you are busy to the walls and somebody is shot across the street, it's not appropriate."

Guidelines need to be locally determined, Auer stresses. "Different hospitals have different resources, and they need to set guiding principles based on those resources, and keeping their own personnel safe," she says.

The Ravenswood incident was an unusual case, which does not make for good law, says Perry. "Every once in a while you have an aberrant case, and somebody dies because care is not rendered to someone on hospital grounds," she notes. "But, most policies are not written for those aberrant cases."

If the legislation is passed, laws must also be passed to protect hospitals from litigation, stresses Perry. "Those laws also have to protect the physician and hospital, because providing services without adequate sterilization and equipment carries legal risk," she explains.

Paramedics have the equipment and expertise to treat somebody on a street corner or sidewalk, whereas ED staff do not, Perry notes. "If they are going to require people to leave the ED, there have to be protections in treating patients outside what they are normally able to," she stresses.

The local response to the legislation was negative. "There has been major fallout," reports Nedza. "An issue that frequently comes up is the fact that two of our hospitals are located across the street from each other. So in that case, who would go out into the street to care for a patient? In other cases, hospitals have parking lots with 2000 square feet."

The incident also had some repercussions in the EMS community. "In this particular instance, the issue arose that if the ambulance had arrived initially, the patient would never have transported to that ED in the first place," says Nedza.

The local chapter of ACEP has taken the position that policies should be decided by individual hospitals. "To come up with an arbitrary distance isn't appropriate," says Nedza. "Every hospital needs to write a specific policy related to these types of incidents, keeping in mind EMS response times and what is happening in the ED at a given time."

Federal legislation setting the same standards for every hospital is not a good solution, says Nedza. "To require that hospitals have a plan in place that is monitored by a legislative body like JCAHO would make a lot more sense," she suggests. ■

Physician CME Questions

22. It is not acceptable for a hospital to go on "ambulance bypass," refusing to receive patients by ambulance when they are too busy to care for them properly.
    a. True
    b. False

23. According to the article on COBRA liability for pre-hospital destination decisions, factors to reduce legal risks posed by complaints include all of the following *except*:
    a. listening to patients.
    b. keeping a paper trail.
    c. referring all complaints to risk management.
    d. not acknowledging errors until legal counsel is notified.

24. Under which of the following conditions should risk management be notified?
    a. Threats (formal or telephoned) that intimate lawsuits
    b. Situations with bad outcomes
    c. Misdiagnoses
    d. All of the above

25. When reviewing hospital policies regarding staff caring for patients outside the ED, which of the following options should be considered?
    a. Avoid prohibiting staff from leaving the ED
    b. Make sure staff understands the hospital's policy.
    c. Know EMTALA regulations.
    d. Consider safety to ED staff.
    e. All of the above.

In Future Issues:

Asthma