ED Legal Letter™

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Federal law, EMTALA, and state law enforcement: Conflict in the ED?

Robert A. Bitterman, MD, JD, FACEP, President, Bitterman Health Law Consulting Group, Charlotte, NC; Vice President, Emergency Physicians Insurance Company, Auburn, CA

Editor's note**: During the time that emergency medical staff and hospitals have operated under EMTALA, court decisions relating to EMTALA and the rules and regulations promulgated by the Centers for Medicare and Medicaid Services have helped to clarify the ramifications of the law. EMTALA pitfalls still exist, however. In this issue, the author discusses the EMTALA issues involved with caring for persons in the custody of law enforcement. Additionally, the author proposes procedures for the emergency department (ED) that would assist the ED staff with remaining compliant with EMTALA while caring for persons in the custody of law enforcement. It may be prudent for ED policy makers to review their procedures for handling law enforcement requests in light of these issues. —**Richard J. Pawl, MD, JD, FACEP

Introduction

Emergency physicians and other hospital ED personnel are often called upon to assist local law enforcement officers with individuals they bring to the ED. There are numerous medical and legal issues related to these interactions, including informed consent for care, custody and restraint, confidentiality or HIPAA regulations, procuring and preserving evidence for criminal prosecutions, and the interactions between state law and federal law, and EMTALA, which govern hospital-based emergency services.

This article will examine three of the more common of these ED scenarios:

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- police requests to draw blood alcohol levels;
- requests for medical 'jail clearance'; and
- sexual assault exams and evidence collection.

It will focus specifically on the Centers for Medicare and Medicaid Services' (CMS) most recent significant changes in the EMTALA regulations and interpretive guidelines that directly address each scenario.

Police Requests for Blood Alcohol Draws

Managing persons brought to the ED by law enforcement officials to obtain a blood draw for measuring their alcohol level is fraught with controversy and risk. There are two primary issues that must be addressed by your ED:

- Does federal law, EMTALA, require the hospital to provide a medical screening examination (MSE) to individuals brought to the ED in police custody for a legal blood draw; and
- What is the most practical and equitable way to provide this service (legal blood draw) in the ED, while simultaneously expediting the process for the police officers and still protecting the hospital and clinical staff from liability?

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Managing Editor: Martha Jo Dendinger

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Basis of Concerns

The legal and medical problems surrounding this ED interaction arise mostly from three sources. First, these individuals often have occult medical problems or injuries associated with, or instead of, alcohol intoxication that warrant examination and treatment by a physician. In fact, persons arrested for 'drunk driving' or who are involved in car accidents or other altercations are actually not brought to the ED for blood alcohol testing (BAT); they are brought to the ED because the police noticed aberrant behavior and ***suspected*** it to be caused by alcohol intoxication. Many conditions mimic alcohol intoxication—hypoglycemia, cerebral hypoxia, head injury, metabolic abnormalities, and ingestion of toxins other than alcohol (**Table 1**). Though the police officer's assessment most often will be correct, alcohol intoxication should not automatically be presumed to be the cause of a patient's condition. The diagnosis and treatment of alcohol-related patients in hospital EDs is a historically well known high-risk encounter.

Second, the Centers for Medicare and Medicaid Services' new EMTALA regulations and interpretive guidelines relating to EMTALA's screening mandate for police blood draws may be misunderstood, create confusion, or provide a false sense of security in the management of these patients.[1,2] Furthermore, even if the hospital's conduct complies with federal law and EMTALA, it still may expose the hospital to malpractice liability under state law.

Third, when the patient has been drinking alcohol, the hospital and emergency physician must balance the patient's autonomy, the right to refuse examination or treatment, with the physician's responsibility to protect individuals who are intoxicated and medically incapable of making informed decisions to refuse medical care. This tension between a patient's right to choose and a physician's duty to protect intoxicated individuals from harm also contributes to the difficulty in managing these interactions and the attendant liability under both federal and state law.

Legal Authority - The Emergency Medical Treatment and Labor Act (EMTALA)

Under EMTALA, "if any individual comes to the

TABLE 1. Conditions That Can Mimic Alcohol Intoxication

- Hypoglycemia
- Hypoxia
- Head injury
- Metabolic abnormalities (e.g., hyponatremia or hypercalcemia)
- Stroke
- Severe hyperglycemia
- Hepatic encephalopathy
- Psychosis
- Encephalitis
- Carbon dioxide retention (as in COPD)
- Vertigo
- Psychomotor seizures
- Seizure disorder
- Drug overdose
- Other alcohols (e.g., methanol, ethylene glycol, or isopropanol)

ED, and a request is made on the individual's behalf for examination or treatment of a medical condition, the hospital must provide for an appropriate medical screening examination …" [3]

Thus, there are two 'prongs' required to trigger EMTALA's duty to provide an MSE:

1. An individual must "come to the emergency department," and
2. "Request examination or treatment for a medical condition."

Under the statute and implementing regulations, it's obvious that in the outlined scenario the person brought to the ED by police meets the legal definition of 'coming to the emergency department' (now defined as a 'dedicated emergency department' (DED by CMS).[4] Therefore, the only real issue is whether the police officer's request for a blood draw for blood alcohol testing (BAT) constitutes a 'request for examination or treatment of a medical condition' that would trigger the hospital's duty under the law to provide an MSE.

One would think that whether a 'request' existed would be simple to determine. However, CMS's new rules actually make this quite difficult, and potentially a highly litigious issue for hospital EDs, by creating an 'implied request' based upon the individual's behavior judged through a prudent layperson (PLP) standard.

Note first that the 'request' in the statutory language is for examination or treatment of a *medical condition;* the law does not say for an *emergency medical condition*—an important distinction, which is commonly misunderstood by hospitals, physicians, attorneys, and commentators. The purpose of the MSE is to determine if the patient's presenting condition is an *emergency* medical condition (EMC), as defined by law.[4,5]

The statute does not define the request prong any further, but CMS's regulations and interpretive guidelines explicitly address the 'request' issue related to police BAT.

Legal Authority - CMS Regulations and Interpretive Guidelines

The relevant section of the regulations on the 'request' prong is:

> *"the individual … requests examination or treatment for a medical condition, or has such a request made on his or her behalf. In the absence of such a request by or on behalf of the individual, a request on behalf of the individual will be considered to exist if a prudent layperson observer would believe, based on the individual's appearance or behavior, that the individual needs examination or treatment for a medical condition; …* [6]

The request may be made by anyone, and it may be expressed or implied by word or by deed. The request may be made by the patient, a family member, a medic, or a law enforcement officer; it doesn't have to come from the patient. Additionally, in absence of an actual request, CMS will presume a request exists if a prudent layperson observer would believe the individual needs examination or treatment for a *medical condition*. (Although CMS recognizes that hospital personnel must be aware of the individual's presence and appearance or actions that indicate a need for examination or treatment for a medical condition before the hospital would incur a duty to screen the individual under EMTALA.[7]

This PLP standard for creating a 'request' is especially relevant in persons brought to the ED for BAT; commonly their behavior, appearance, or obvious intoxication would lead a PLP to believe the person needs examination or treatment for a medical condition. CMS interprets the PLP standard to be an implied request for an MSE and that the hospital is on notice that a request for an MSE existed. Therefore, the only way the hospital can avoid its duty to

provide an MSE is if the individual refuses the MSE offered by the hospital. The refusal would need to be an informed refusal, after the emergency physician has determined that the patient was medically competent to refuse examination and treatment.

In the regulations CMS attempted to avoid imposing a duty on hospital's to provide an MSE for traditionally nonemergency services, such as BAT, stating if

> *"the nature of the request makes it clear that the medical condition is not of an emergency nature," then the "hospital is required to only perform such screening as would be appropriate for any individual presenting in that manner, to determine that the individual does not have an EMC."* [8]

However, this new regulation didn't change anything! The hospital still must perform an MSE to the extent necessary to determine if an EMC exists. In other words, the scope of the MSE must be whatever it takes to decide if an EMC exists in the same manner as would be done for anyone else presenting with the same complaint (the two elements of an "appropriate" MSE established by the courts—"reasonably calculated" and "uniform"). Thus, all patients presenting with a medical condition must be provided an MSE to determine if that medical condition is an *emergency* medical condition.

CMS's Interpretive Guidelines of May 13, 2004, state the following regarding police blood alcohol testing in the emergency department:

> *"If an individual presents to a dedicated emergency department and requests services that are not for a medical condition, such as … gathering evidence for criminal law cases (e.g., … blood alcohol test) the hospital is not obligated to provide an MSE under EMTALA to this individual."* [9]

Thus, at first glance is appears that CMS believes persons presenting for a blood alcohol draw for BAT would not require an MSE, because essentially CMS is considering BAT to not count as a medical condition. However, CMS's guidelines further state:

> *"Attention to detail concerning blood alcohol testing (BAT) in the ED is instrumental when determining if an MSE is to be conducted. If an individual is brought to the ED and law enforcement personnel request that emergency department personnel draw blood for a **BAT only** and does not request examination or treatment of a medical condition, such as intoxication and a prudent lay person observer would not believe that the individual needed such examination or treatment, then the EMTALA's screening requirement is not applicable to this situation because the only request made on behalf of the individual was for evidence. However, if for example, the individual in police custody was involved in a motor vehicle accident or may have sustained injury to him or herself and presents to the ED, an MSE would be warranted to determine if an EMC exists."* [10]

And CMS continues:

> *"Surveyors will evaluate each case on its own merit when determining a hospital's EMTALA obligation when law enforcement officials request screening or BAT for use as evidence in criminal proceedings."* [11]

These last two paragraphs reiterate the PLP standard for creating a request for an MSE, even though the individual is presenting purely for a blood draw for BAT. CMS will retrospectively review details from police reports, nursing notes, EMS run sheets, triage information, and interaction/interview of the patient to determine whether there was an actual or implied (e.g., PLP standard) request for an MSE. If the patient gives the slightest hint that he/she wants to be examined, or says or does something to suggest to a PLP that he/she needs to be examined, then the hospital's duty to provide an MSE will be triggered.

In my experience, CMS considers persons with substance abuse problems, including alcohol-related problems, to be a 'protected class', and therefore applies greater scrutiny in evaluating their care by the hospital.[12] Due to concerns that these patients often are given short shrift by EDs, and may have occult injuries or medical conditions that present similar to alcohol intoxication, the CMS regional offices expect hospitals to extensively interview police officers and the patient to determine whether a medical issue exists. Many state surveyors and regional offices also question whether an intoxicated patient can make an informed refusal of care. If an individual suffers an adverse outcome, CMS or a

jury could easily conclude retrospectively that the person had an EMC and that the hospital failed to perform an appropriate MSE or stabilize the EMC.

For example, in the case of *Evans v Montgomery Hospital Medical Center,*[13] police arrested a man for "driving erratically and acting abnormally." The police took him to the hospital's ED for a blood alcohol test to use in criminal proceedings. A nurse drew the blood, but the patient was not seen by the emergency physician, and police took the man to jail. The next morning, he was found dead in his cell from a stroke; his aberrant behavior the night before was the result of cerebral hypoxia, not alcohol. The man's estate sued the hospital, claiming that it failed to provide the patient an appropriate MSE as required by EMTALA. The court determined that the man had requested examination or treatment for a medical condition and accepted the plaintiff's argument, for two reasons:

1. the decedent had signed the hospital's usual ED consent to hospital examination and treatment form. The court held that signing the standard hospital consent form was substantial evidence that the man had sought treatment for a medical condition; and

2. the man's obvious lethargy and difficulty sitting up without assistance while the nurse drew his blood also represented an apparent request for examination and treatment.

Evans was before CMS's prudent layperson standard, but the court had no trouble finding that behavior manifestly indicative of a need for medical evaluation did indeed trigger EMTALA's MSE mandate upon the hospital.[13]

In a case decided after CMS's new 'request' rules became effective, *Kraft v. Laney,*[14] the patient went into cardiac arrest while the nurse was drawing blood for the police-requested blood alcohol test. Here too, the patient had not been seen by the emergency physician. The family sued the hospital and emergency physician claiming they violated EMTALA by not performing an MSE. The court disagreed, holding that EMTALA did not apply yet because neither the patient nor the police requested examination or treatment; and the hospital had no duty to provide an MSE unless it was clear to it that the patient was suffering an emergency medical condition (i.e., the hospital and physician were not aware that the patient's presentation met the PLP standard yet). The court noted that the hospital did perform an MSE and attempted stabilizing treatment once the physician became aware that the patient went into cardiac arrest. (Actually, the court erred a bit; EMTALA only requires that the patient appear to be suffering from a 'medical condition' that needs examination or treatment, not from an '*emergency* medical condition'. See earlier discussion above.)

Summary

Under CMS's new standard, the only way for the hospital to ensure that BAT patients brought by police don't have medical or trauma issues, and that the PLP standard is not present, is for its clinical staff to interact with the patient. Potentially intoxicated patients are at high risk for harm, and the hospital should always attempt to provide an MSE.

CMS believes alcohol intoxication to be a "sufficiently severe medical symptom to warrant the label "emergency medical condition," [12] and therefore, an intoxicated individual has an EMC until the hospital proves otherwise. If such an individual has an adverse outcome, CMS can easily conclude retrospectively that the individual had an EMC at the time of presentation and that the hospital failed to perform an appropriate MSE and failed to stabilize the EMC. Additionally, the civil courts may determine that EMTALA requires the hospital to provide an MSE to these individuals.

Nurses may be able to judge the situation in most instances, but not as well as physicians, and they can't determine medical competence under the state's nurse practice act. The crux of the message is that emergency physicians need to be actively involved in the management of these patients in the ED.

Recommendations

In light of the above, I believe that anytime an individual is brought to the ED by police officers for blood alcohol testing, the **emergency physician**, for both medical and legal reasons, should personally interact with that person, offer to provide an MSE to determine if an emergency medical condition (EMC) exists, and ascertain whether the person is medically competent to refuse the offered screening examination.

Triage

The following approach is suggested for handling the scenario of law enforcement personnel bringing individuals under their custody to the ED for blood alcohol testing:

All such persons are triaged, including vital signs, just like any other person presenting to the ED. The triage nurse determines the individual's presenting complaint. *If*:

1. the person has no medical complaint;
2. the person does not request an MSE for examination or treatment of a medical condition;
3. the person does not appear to need medical attention for a medical condition; and
4. in the professional judgment of nurse it would be appropriate to simply draw the person's blood and release the person with the police (i.e., the triage nurse doesn't believe the person meets the PLP standard triggering the hospital's duty to provide an MSE, or has any other relevant concerns); *then* the nurse can triage the person to '**Track A - The Fast Track**', as outlined below. If any one of these four criteria is not met, then the nurse triages the patient to '**Track B - The Less Fast Track**', also as outlined below.

Track A - The Fast Track for handling BAT requests by law enforcement.

1. The patient is placed in an examining room (doesn't matter what type of room).
2. The emergency physician is asked to interact with the patient as soon as possible (even ahead of other nonurgent patients who arrived prior to this individual).
3. The emergency physician speaks with the patient and judges whether the patient meets the PLP standard for triggering the request for an MSE.

a. If the patient does not meet the PLP standard, does not want an MSE, and the physician believes the patient is medically competent, the nurses can draw the blood for BAT and discharge the patient from the ED with the police. The physician documents his determination in chosen fashion on the medical record.

b. If the patient does meet the PLP standard, but does not want the MSE, then the physician determines if the patient is medically competent.

(1) If the patient is medically competent, the physician allows the patient to refuse the offered MSE and documents the refusal accordingly. The patient should be asked to sign the hospital's Against Medical Advice (AMA) form (Sample form available in: Bitterman RA, *Providing Emergency Care Under Federal Law: EMTALA*. ACEP;2001.) Nursing draws the blood and discharges the patient into the custody of the police.

(2) If the patient is *not* medically competent, then the physician retains the patient as necessary and examines and treats the patient for any emergency conditions as appropriate until such time as the patient becomes medically competent to refuse further care. Nursing draws the blood for police use as soon as possible.

This '**Fast Track**' option for processing police BAT requests benefits all concerned parties:

- The community benefits through successful prosecution of persons who endanger others when driving while intoxicated, due to timely measurement of the person's blood alcohol level.
- The accused person benefits by timely BAT, which may prove his innocence, and/or by appropriate medical intervention, which may uncover a non alcohol-related medical problem and/or prevent the person from being incarcerated with a significant undiagnosed medical problem.
- The hospital benefits by a system that minimizes its risk of liability under both EMTALA and malpractice law, and which efficiently moves patients through the ED. (In practice, the triage nurses are generally correct, and the physician would only need to spend a few minutes with Track A patients.)
- The law enforcement team benefits, and thus, the community at large, by timely processing persons in its custody in order that they may return to their law enforcement duties.
- The ED staff and the other patients in the ED benefit by minimizing the time these patients—who can be difficult to manage—and the police officers spend in the ED.

Track B - The 'Less Fast Track' for handling BAT requests by law enforcement.

1. The patient is placed in a room to be screened exactly as any other patient presenting with a medical condition. The patient is seen in the order determined by nurse triage criteria (though, for all the reasons stated above, it would not be a violation of the law if the hospital chose to see these patients ahead of others in similar triage categories, using the

TABLE 2. Fast Track Options for Handling BAT Requests by Law Enforcement

TRACK A - THE FAST TRACK FOR HANDLING BAT REQUESTS BY LAW ENFORCEMENT

1. The patient is placed in an examining room (doesn't matter what type of room).

2. The emergency physician is asked to interact with the patient as soon as possible (even ahead of other nonurgent patients who arrived prior to this individual).

3. The emergency physician speaks with the patient and judges whether the patient meets the PLP standard for triggering the request for an MSE.

a. If the patient does not meet the PLP standard, does not want an MSE, and the physician believes the patient is medically competent, the nurses can draw the blood for BAT and discharge the patient from the ED with the police. The physician documents his determination in chosen fashion on the medical record.

b. If the patient does meet the PLP standard, but does not want the MSE, then the physician determines if the patient is medically competent.

(1) If the patient is medically competent, the physician allows the patient to refuse the offered MSE and documents the refusal accordingly. The patient should be asked to sign the hospital's Against Medical Advice (AMA) form (see sample form in the ACEP EMTALA book, reference #5.) Nursing draws the blood and discharges the patient into the custody of the police.

(2) If the patient is not medically competent, then the physician retains the patient as necessary and examines and treats the patient for any emergency conditions as appropriate until such time as the patient becomes medically competent to refuse further care. Nursing draws the blood for police use as soon as possible.

TRACK B - THE 'LESS FAST TRACK' FOR HANDLING BAT REQUESTS BY LAW ENFORCEMENT.

1. The patient is placed in a room to be screened exactly as any other patient presenting with a medical condition. The patient is seen in the order determined by nurse triage criteria (though, for all the reasons stated above, it would not be a violation of the law if the hospital chose to see these patients ahead of others in similar triage categories, using the need to promptly return police to their law enforcement duties as the indicated criterion to advance these patients course through the ED. It is NOT recommended, however, that the emergency physicians advance these patients ahead of patients with higher acuity levels as determined by the triage nurses.)

2. Nursing draws the blood for police use as soon as possible.

3. The emergency physician medically screens the patient in the order determined by nursing triage and hospital policy as discussed in step 1 above.

need to promptly return police to their law enforcement duties as the indicated criterion to advance these patients course through the ED. It is NOT recommended, however, that the emergency physicians advance these patients ahead of patients with higher acuity levels as determined by the triage nurses.)

2. Nursing draws the blood for police use as soon as possible.

3. The emergency physician medically screens the patient in the order determined by nursing triage and hospital policy as discussed in step 1 above.

Additional Issues to Consider

Issue of 'Disparate Treatment'. Some may question whether this process is disparate treatment in violation of the intent of EMTALA and the letter of the law. However, it is no different that triaging certain categories of patients to Labor and Delivery (L&D), certain categories of patients to an urgent care center attached to the ED, or high acuity patients directly back to the treatment area. Each hospital is allowed to determine the process it will use to screen different types of patients coming to its ED, depending upon the presenting complaint and medical triage criteria.

The critical element is that all individuals who meet the established medical criteria go through the same process and that the criteria are not discriminatory. For example, triaging all patients more than 20 weeks' gestation with pregnancy-only related complaints directly to L&D is legal and nondiscrimina-

tory, but triaging only insured patients to L&D and examining the uninsured in the ED would be discriminatory disparate treatment in violation of the law (irrespective if the care was 'better, worse, or equivalent' in one area or the other). It's the same with BAT procedures in the ED. As long as all persons brought by police for legal blood alcohol draws are put through the same process, the hospital is clearly in compliance with EMTALA, even if it accelerates the patient's care through the ED to accommodate the needs of the police.

Patient Refuses the Medical Screening Examination. If at any time the patient refuses to continue down either track, the emergency physician should be involved to determine whether the patient is capable of making an informed refusal of medical care, just like any other scenario where a patient is trying to leave or refuse care against medical advice (AMA). If the physician determines the patient is not medically competent to refuse care at that moment in time, then the physician should retain the patient by whatever means necessary, just as the physician would retain any other patient incapacitated by a medical or psychiatric condition.[15]

Police Attempt to Remove the Patient from the ED. If at any time the police wish to remove the patient from the ED, the emergency physician should be involved to ascertain the circumstances and intercede as indicated. If the police decide to remove the patient against the recommendations of the physician, the hospital will not be liable under EMTALA or state law. It is not the role of the hospital or the ED physician and nursing staff, nor do they have a duty to engage in a struggle with law enforcement personnel. ("Two big guys with guns took the patient" is an adequate defense to protect the hospital and staff from liability.) The ED staff should notify hospital administration/legal counsel, as determined by hospital policy, so that the hospital may report the incident to the appropriate supervisory law enforcement authorities.

The Patient Refuses the BAT. The individual brought to the ED by police for an alcohol level may refuse to allow the blood draw. EMTALA does not preempt a state's informed consent laws, so health care providers still must obtain the individual's consent before performing the procedure (absent any reason for the physician to invoke the state's 'emergency doctrine').[16] Many states have 'implied consent to medical testing' laws, so if the person refuses the test he/she may suffer adverse legal ramifications, such as admissibility of the refusal as evidence against him/her in a subsequent criminal action.[17]

If the patient refuses the police-requested BAT, the police generally must obtain a subpoena from a court of competent jurisdiction to compel the individual to allow the blood draw. In some states, though, the charging office can forcibly compel the drawing of the blood sample without a subpoena if the officer certifies, in writing, that: 1) there is probable cause for obtaining the blood sample from the patient; 2) obtaining a search warrant would cause unreasonable delay and irreparable harm by impairing the accuracy of the blood sample; and 3) the officer has complied with the statutory procedural requirements. [17,18]

The Patient Refuses to Comply with a Subpoena, or Threatens the Staff. If the patient refuses to cooperate with the blood draw done under subpoena power (or through certification by the officer as noted above), or if the hospital staff feels threatened in any way, it is the responsibility of the police authorities to sufficiently control the patient for the procedure to be done.[17,18] If the staff members ever feel their safety is in jeopardy, they may decline to draw the blood until the responsible police agency controls the patient. (However, as always, if the physician deems the behavior to be medically induced and/or the patient to be medically incompetent, then the hospital does have a duty to restrain, examine, and treat the patient.)

Liability of Hospital Personnel for Drawing the BAT Sample. Almost universally, under the various state laws, hospital staff is granted qualified immunity from civil and criminal liability when drawing blood in good faith pursuant to a charging officer's request, certification, or subpoena.[19] Typically, there is no immunity from liability for negligent acts or omissions, such as poking an artery instead of a vein and negligently forgetting to apply pressure for an adequate period of time. Health care professionals always remain liable for their professional malpractice.

ED Policy and Procedure Considerations

Regardless of how the hospital decides to handle blood draws for BAT in the ED, it should implement written policies and procedures to address the situation. Following the policy proves the hospital's intent to provide screening examinations to all who

ask or need one, and demonstrates its intent to provide other services to the community. The process of writing and adopting these policies requires the EMTALA issues to be addressed, educates the medical staff and hospital administrators on the issues, and helps prevent errors.

Additionally, conspicuously document that the individual did not request an MSE for examination or treatment of a medical condition. For example, use a check box on the general ED consent form, signed by the patient, which indicates the patient's intent, (e.g., "I do not request a medical screening examination to determine if I have an emergency medical condition," or "I do not request examination or treatment for a medical condition at this time. I understand that the hospital is willing to provide me with examination and treatment if I ask for it.") The hospital should save the paperwork for at least 5 years in case it becomes necessary to prove to CMS or a court that the individual did not request examination or treatment.

Medical Clearance for Incarceration

CMS guidelines state:

"When law enforcement officials request hospital emergency personnel to provide clearance for incarceration, the hospital has an EMTALA obligation to provide an MSE to determine if an EMC exists."[20]

This declaration is not always true, depending upon on the circumstances. If a police officer or a sheriff's deputy arrests someone and brings him/her to the ED for 'jail clearance', whether the hospital must provide a medical screening exam depends upon exactly how that request is framed. If the individual under arrest has no medical complaints and the officers simply want the person 'checked out' so he's okay to be placed in jail, then no EMTALA duty attaches (but remember the PLP implied request standard may apply). The 'request' required to trigger EMTALA must be one for 'examination or treatment for a medical condition'.[3]

For example, upon learning the person arrested has insulin-dependent diabetes, the police bring the person to the ED and ask the emergency physician to check the patient prior to incarceration. If the person has no medical complaints, the hospital has no legal duty to examine the person. If this were true, then every parent could bring their child in for school physicals, or sport physicals by merely stating they want the child examined or that the child has asthma and needs a doctor's permission to play sports. If the prisoner complains of polyphagia, polyuria, and polydipsia, or the student complains of wheezing and shortness of breath, then there exists a request for examination or treatment of a medical condition.

On the other hand, if the person under arrest was injured during the arrest or is ill in some way, then the hospital definitely incurs a duty under EMTALA to medically screen the individual. The extent of the exam though, need only be that which is necessary to determine if an EMC is present; it need not be a more encompassing admitting history and physical examination that the jailers are typically seeking. Hospitals and emergency physician groups are free to provide these services gratis to local law enforcement or seek advanced contractual arrangements for payment of the services rendered.

Naturally, law enforcement could game the system to some extent, by raising 'medical complaints' to force the ED to examine these individuals under EMTALA (at least to the point of determining whether an EMC is present), but generally the parties can reach mutually beneficial solutions through good will and practical politics.

The CMS guidelines also state "Surveyors will evaluate each case on its merit when determining a hospital's EMTALA obligation when law enforcement officials request screening … ." [20] Hopefully, this means that hospitals are not required to perform MSEs on everyone who presents to the ED, particularly those who are not really seeking examination or treatment for a medical condition.

Collection of Evidence in Cases of Alleged Sexual Assault

ED personnel frequently help police officers in the collection of evidence related to alleged sexual assault. If an individual comes to the ED ***solely*** to provide evidence for a criminal investigation, that individual is not requesting "examination or treatment for a medical condition," so no MSE is required. If the hospital uses a community 'SANE' (sexual assault nurse examiners) team approach, these individuals do not need to be designated or

trained as 'qualified medical personnel' (QMPs) because their evaluation of the alleged assault victim is not an EMTALA MSE; the purpose of the SANE exam is not to determine if an EMC is present; the purpose is to collect evidence. (*Editor's note: In the SANE approach, a victim of child, elder, or domestic abuse sees one or two female specialists from intake to the physical examination and treatment to the collection of forensic evidence, thereby reducing the need for multiple health care professionals.*)

However, if the individual complains of pain or injury or asks for pregnancy or sexually transmitted disease prophylaxis or treatment, that individual is requesting "examination or treatment for a medical condition" and must be provided an MSE.

CMS states that:

> *"… the hospital must be able to document that it is only being asked to collect evidence, not analyze the test results, or to otherwise examine or treat the individual."* [20]

Once again, the hospital must remember the PLP implied request standard may apply, so the emergency physician may need to scour all the ED triage and nursing records, even any EMS records, to be sure that no 'medical complaints' exist in the record.

To avoid any confusion, it is strongly recommended that the hospital have the individual sign an informed consent to refuse treatment form that documents that he/she is not requesting or are specifically refusing the MSE, and the emergency physician also should sign the document indicating that the person appears medically competent to make that decision and that there are no indicators of an implied request for an MSE. [5,21]

Hospital policy also should designate who is qualified and trained to participate in collecting evidence. The policy should explicitly limit the scope of the examination to prohibit evaluation of an alleged victim's medical complaints, which is the role of the hospital's designated medical screening personnel.

The key point is that every time a person presents ***solely*** for evidence collection, whether the evidence is a blood alcohol measurement or sexual assault forensics, the hospital absolutely must document that the person is not requesting an MSE.

Endnotes

1. 68 Fed. Reg. 53,221-53264 (2003). The new final EMTALA regulations on EMTALA published by CMS can be found at 42 CFR 489.24 or via the Federal Register Online GPO Access at: http://www.access.gpo.gov/su_docs/fedreg/a030909c.html under "Separate parts in this issue."
2. HHS CMS/Survey and Certification Group. S&C-04-34, Revised Final EMTALA Interpretive Guidelines, May 13, 2004. Available at: http://www.cms.hhs.gov/medicaid/survey-cert/sc0434.pdf. (The section near the end of Tag 406 specifically addresses police blood alcohol testing in the emergency department, and the other issues addressed by this article.)
3. 42 USC 1395dd(a).
4. 42 USC 1395dd(a); 42 CFR 489.24(b)(1).
5. Bitterman RA. *Providing Emergency Care Under Federal Law: EMTALA*. American College of Emergency Physicians 2001. A supplement addressing the impact of the new 2003 EMTALA regulations was published in May of 2004. (Pages 39-40 specifically address the 'police blood alcohol draw' by hospital emergency departments under EMTALA.)

6. 42 CFR 489.24(b)(1).
7. 68 Fed Reg 53221-53264 (2003).
8. 42 CFR 489.24(c).
9. CMS Interpretive Guidelines May 13, 2004, Tag 406, page 34.
10. Ibid. (Emphasis in the original.)
11. CMS Interpretive Guidelines May 13, 2004, Tag 406, pages 34-35.
12. 59 Fed Reg 32107-32108 (1994).
13. *Evans v Montgomery Hospital Medical Center,* Case No CIV A 95-5039, 1996 US Dist LEXIS 5785, (ED Pa May 1, 1996).
14. *Kraft v. Laney*, No. CIV S-04-0129 GGH (E.D. Cal. Aug. 24, 2005).
15 Bitterman RA. Chapter 200: Medicolegal Issues. In: *Rosen's Emergency Medicine: Concepts and Clinical Practice*, 5th Edition 2002, Marx JA, ed. (Discusses the medical and legal issues related to persons refusing a medical screening examination under EMTALA and state laws, or a patient's refusal of stabilizing treatment that is entirely controlled by EMTALA.)
16. *Tinius v. Carroll County Sheriff Department and St. Anthony Hospital*, 321 F.Supp. 2d 1064 (N.D. Iowa June 14, 2004).
17. N.C. Gen. Stat. §20-16.2 (2003)
18. N.C. Gen. Stat. §20-139.1 (2003).
19. American College of Legal Medicine. *Legal Medicine*, 5th ed. Mosby Publishing Co;2004.
20. CMS Interpretive Guidelines, Section 489.24(c).
21. *CM v. Tomball Regional Hospital*, 961 S.W.2d 236 (Tex. App. 1997).

CE/CME Questions

1. When a person in custody of a law enforcement officer presents to the ED for the purpose of obtaining a blood alcohol test (BAT), which of the following conditions would assist the hospital staff in determining that there is no EMTALA obligation to perform a medical screening exam?
   A. The apparently intoxicated person in custody is willing to sign an an informed refusal of medical care form.
   B. The triage nurse's evaluation determines that there is no apparent medical condition in the person in custody to warrant a medical screening exam.
   C, The law enforcement officer is willing to sign an informed refusal of medical care form.
   D. A and C
   E. None of the above.

2. Under the 'Fast Track' option proposed by the author for handling BAT requests from law enforcement, the emergency physician does not need to evaluate the person in custody.
   A. True
   B. False

3. If a person in custody of a law enforcement officer refuses to have a BAT in the ED, the ED staff may take a BAT from the patient against that patient's will if:
   A. the officer certifies in writing that the BAT is required for the purpose of prosecuting a drunken driving charge against that patient.
   B. the officer presents a subpoena from a court of law requiring that a BAT is obtained from the person in custody.
   C. the physician determines that the patient is not competent to refuse a medical evaluation.
   D. A and C
   E. None of the above.

4. When a patient presents to the hospital with law enforcement for the purpose of obtaining evidence for the criminal investigation of the sexual assault of that patient:
   A. the hospital always incurs an EMTALA obligation.
   B. the sexual assault nurse examiner may perform an EMTALA medical screening exam during the course of the collection of evidence.
   C. the sexual assault nurse examiner is only required to collect evidence for the purpose of the criminal investigation.
   D. A and C
   E. None of the above.

5. Which of the following conditions is/are considered a 'prong' required to trigger an EMTALA duty to provide an MSE?
   A. An individual must come to the emergency department.
   B. An individual requests examination or treatment for a medical condition, or a prudent layperson could identify that the individual is in need of medical help.
   C. An individual must be accompanied by a law enforcement officer.
   D. A and B

6. Which of the following conditions may mimic alcohol intoxication?
   A. Hypoglycemia
   B. Severe hyperglycemia
   C. Carbon dioxide retention
   D. Hepatic encephalopathy
   E. All of the above

Answers:
1. B
2. B
3. B
4. E
5. D
6. E

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Participants who complete this activity will be able to:

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- discuss a standard of care in the ED for treatment of conditions that may be considered as high risk;
- explain conditions and practices in which informed consent is required in the ED;
- cite methods of minimizing risk in the ED setting.

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Physicians and nurses participate in this continuing medical education/continuing education program by reading the article, using the provided references for further research, and studying the questions at the end of the article. Participants should select what they believe to be the correct answers, then refer to the list of correct answers to test their knowledge. To clarify confusion surrounding any questions answered incorrectly, please consult the source material.

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Thomson American Health Consultants
Building Six, Suite 400
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Tel (404) 262-7436 Fax (404) 262-7837
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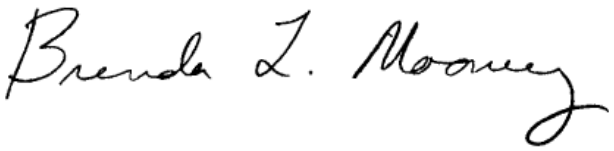

Brenda Mooney
Vice-President/Group Publisher
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