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Transferring Patients: EMTALA Rule to Apply to Those Needing More Care

Change would determine whether hospitals with specialized services must accept appropriate transfers

by Robert A. Bitterman, MD JD FACEP, *Contributing Editor*

In April of this year the Centers for Medicare and Medicaid Services (CMS) proposed changes to the Emergency Medical Treatment and Active Labor Act (EMTALA) regulations that would once again significantly impact EMTALA's patient transfer rules.[1] (Please see "Proposed EMTALA Changes" in sidebar.)

Historical Perspective

Back in 2003, in its EMTALA "final rule," CMS took the position that a hospital's obligation under EMTALA ended when that hospital admitted an individual with an unstable emergency medical condition, in good faith, as an inpatient to that hospital.

Proposed Changes to EMTALA

CMS's proposed EMTALA changes also would alter the physician on-call requirements. Most notably, CMS would allow "community call" programs to be established by groups of hospitals in self-designated referral areas to help address the shortage of on-call specialists serving on hospital ED call panels. A community system could be set up to address a specific medical service, such as hand surgery, and/or a specific time frame, such as just on the weekends. The involved hospitals would need to establish a formal written plan, but no advanced approval from CMS would be required.

Each community program would need to, however, meet a list of minimum criteria provided by CMS, and each hospital in the program would still be required to medically screen, stabilize, and arrange an appropriate transfer when sending selected patients to the "community call" facility. The on-call changes will be covered in a future *ED Legal Letter* article.

CMS acknowledged that other patient safeguards protected inpatients, such as the Medicare conditions of participation and State malpractice laws, but many questions remained regarding the applicability of the EMTALA requirements to inpatients.

One question, in particular, persisted. In the 2003 final rule, CMS did not directly address the question of whether EMTALA's "specialized care" transfer acceptance requirements applied to inpatients.[2]

Wording of Patient Transfer Law. This transfer acceptance section of the law is referred to as the "non-discrimination" clause or "section (g)" of the law and it states that:

> "A Medicare participating hospital that has specialized capabilities or facilities such as burn units, shock-trauma units, neonatal intensive care units, or (with respect to rural areas) regional referral centers as identified by the Secretary shall not refuse to accept an appropriate transfer of an individual who requires such specialized capabilities or facilities if the hospital has the capacity to treat the individual."[3]

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This is broad language and does not specify whether hospitals with specialized services must accept appropriate transfers just from the emergency departments of other hospitals, or whether they must also accept appropriate inpatient transfers from other hospitals.

Many attorneys and hospitals (particularly tertiary/academic medical centers) believe that since EMTALA ends once the patient is admitted, no other hospital has any EMTALA obligations to that patient.

Others, including this writer, believe that the non-discrimination section imposes an independent duty upon accepting hospitals, and that their duty to accept transfers is not derivative or dependent upon the EMTALA duties of the other hospital. In other words, just because EMTALA ends for one hospital when it admits the patient does not mean the law does not apply to a different hospital when it is asked to accept an appropriate transfer of a patient who needs further emergency care.

No Differentiation of In-patients vs. ED Patients. The language of section (g) does not differentiate inpatients from ED patients, nor, incidentally, does it differentiate stable patients from unstable patients.

Section (g) should be interpreted to mean that if the patient has an emergency medical condition (EMC) that the current hospital can't manage, then a receiving hospital with the capability and capacity to care for the EMC must accept the patient in transfer, regardless of the location of the patient in the sending hospital and regardless of whether the patient is currently stable or unstable.

To interpret the law otherwise would lead to the absurd behavior of physicians and hospitals refusing to admit patients from the ED if a transfer seemed potentially indicated, or accepting hospitals refusing to accept critically ill or injured inpatients because of their insurance status. They also might refuse to treat major trauma patients from small town EDs because a patient was temporarily "stable" under the law, but clearly would deteriorate or die if he or she was not transferred in a timely manner to a facility that was capable of managing the patient's emergent injuries.

Such behavior already occurs regularly with psychiatric patients. Hospitals with inpatient psychiatric facilities and capabilities routinely refuse to accept suicidal or overtly psychotic patients in transfer (patients who clearly meet EMTALA's legal definition of an EMC) because of insurance reasons, claiming that they do not have to accept stable patients in transfer. (Hospitals can legally stabilize psychiatric patients with EMCs, particularly patients with suicidal ideation

or intent, by preventing them from harming themselves or others via restraints, pharmacological agents, or seclusion even when they are totally incapable of treating their suicidal ideation.)

Referral Hospitals and Patient Acceptance. Additionally, remember that the non-discrimination section was not part of EMTALA originally. It was later added as an amendment because referral hospitals were refusing to accept patients in transfer from other hospitals because of their insurance status and the patients were dying in the ED and dying in the inpatient settings. Congress' intent when it passed section (g) was to prohibit our more capable hospitals from refusing for economic reasons transfers of patients with emergency conditions that the original hospital couldn't handle. Hence the title of the section: "non-discrimination."

The plain language of the non-discrimination section does not condition the acceptance of such patients on their location in the transferring hospital, whether their EMC is stable or unstable at the time of transfer, whether they entered the hospital via the ED, or whether the law still applies to the transferring hospital at that time the transfer is medically necessary.

Unfortunately, patients once again are at risk of death, just like before EMTALA was passed, because referral hospitals are now refusing transfers of individuals with emergency conditions on account of their insurance status "because EMTALA ended upon admission." The issue is certain to be litigated, as unquestionably inpatients with emergencies that their hospital can't handle will suffer morbidity and mortality when referral hospitals refuse to accept them in transfer and treat the emergency. To my knowledge, however, the courts have not yet addressed this issue in civil cases brought under EMTALA.

CMS and the EMTALA Technical Advisory Group

CMS Enforcement. CMS presently only enforces the transfer acceptance section against hospitals that refuse medically indicated transfers from an ED, not if they refuse transfers from the inpatient setting. However, that may be about to change.

Recently, an EMTALA Technical Advisory Group (TAG), established by Congress through the Medicare Prescription Drug, Improvement, and Modernization Act to review the EMTALA regulations and advise CMS on their application to hospitals and physicians, recommended that CMS finally answer the question of whether section (g) applies to inpatients.[4]

The TAG expressly asked CMS to address the situation of an individual who:

1) presents to a hospital that has a dedicated emergency department and is determined to have an unstabilized emergency medical condition;
2) is admitted to the hospital as an inpatient; and
3) is subsequently determined by the hospital to have an emergency medical condition (EMC) that needs stabilizing and that requires specialized care only available at another hospital.

CMS Response: EMTALA Obligations of Other Hospital's Intact. CMS responded by first stating that EMTALA's section (g) does indeed require hospitals to accept appropriate transfers regardless of whether the patient is in the ED or the inpatient setting. It agrees that once the individual is admitted, admission only impacts on the EMTALA obligation of the hospital where the individual first presented, not the EMTALA obligations of other hospitals.[1]

However, it qualified its interpretation to apply only to inpatients who were originally EMTALA patients determined to have an unstabilized EMC and that after admission the hospital subsequently determines that stabilizing the patient's EMC requires specialized care only available at another hospital.[1]

Therefore, the elements of CMS's new proposed requirement that hospitals must accept appropriate transfers of inpatients include the following:

1. The individual must have presented to the hospital under EMTALA;
2. The hospital must determine that the individual has an EMC that is unstabilized;
3. The individual must be admitted to the hospital;
4. The individual's EMC must have remained unstable since the time of admission;
5. The hospital must be unable to stabilize the EMC; and
6. The receiving facility has the capacity and capability to treat the patient's EMC.

Caveats to the Proposed Requirements. There are a number of sticky caveats to CMS's criteria. First, this does not mean the patient must have initially presented to the hospital's dedicated emergency department. EMTALA attaches to patients presenting to the hospital in other ways, such as to labor and delivery or psychiatric intake centers; to patients presenting "on hospital property" with what appears to be an emergency condition; and to patients entering a hospital via owned and operated ambulance or helicopter.

Second, this proposed rule excludes patients who were electively admitted or directly admitted to the hospital and who subsequently develop an emergency condition while in the hospital that the hospital can't stabilize. For example, assume a person was directly

admitted to a hospital cardiac unit from a physician's office with atrial fibrillation. This patient is anticoagulated, bumps his head, and sustains an expanding epidural hematoma that requires immediate neurosurgical intervention. The hospital has no neurosurgeon on staff, so it attempts to transfer the patient to a hospital that does have neurosurgical services. Since the patient didn't "present to the hospital under EMTALA," the accepting facility has no legal duty under EMTALA to accept the patient in transfer. If it so chooses, it can accept the insured patient and reject the uninsured patient with no legal ramifications under the law.

Third, it also excludes any patient who enjoys a period of stability after admission to the hospital but who subsequently becomes unstable again, even if the hospital is no longer capable of stabilizing the patient and needs to transfer the patient to a higher level facility. One example of this issue is the trauma case cited above. However, there are numerous medical, surgical, and traumatic scenarios in which patients with EMCs are stable when admitted but may quickly become unstable and require transfer to another more capable hospital. For example, a child with a closed head injury but a negative initial CT scan who is admitted to a hospital that does not have a neurosurgeon who later decompensates. Another possibility would be a patient with uncontrolled pain from a 5 mm obstructing ureter stone that is expected pass spontaneously with time who is admitted to an internist in a hospital without urology coverage. This patient might later develop an infection behind the obstruction and need acute urological intervention. Hospitals will stop admitting these type of patients in the first place if they can't get them transferred later should the patient's condition deteriorate.

Provider Input Sought by CMS Before It Issues a Final Rule

CMS recognizes some of the problematic issues with its proposed expanded interpretation of the transfer acceptance mandate of EMTALA. It is, therefore, seeking public comments on its proposed new regulation. It is seeking input about whether, with respect to the EMTALA obligation on the hospital with specialized capabilities, it should or should not matter if an individual who currently has an unstabilized emergency medical condition (which is beyond the capability of the admitting hospital):

1) remained unstable after coming to the hospital emergency department or;
2) subsequently had a period of stability after coming to the hospital emergency department.[1]

Conclusion/Comments

However, it shouldn't matter how the patient presented to the hospital, where the patient is located in the hospital, or whether the patient is unstable or temporarily stable at the time of transfer. If the patient has an EMC, and the hospital is unable to treat that emergency condition and it is medically indicated that the patient be transferred to another hospital to treat the EMC, then EMTALA's non-discrimination section should require the receiving hospital to accept the patient in transfer whenever it is capable of treating the emergency.[5,6]

Section (g) uses the word "appropriate" transfer in its ordinary meaning sense; it is not used in any sense defined by the statute, as "an appropriate transfer" is for the transfer of unstable patients. Therefore, it should mean, as Congress intended, that higher level facilities should accept medically indicated transfers of patients with emergency conditions when they can do so, and on a non-discriminatory basis.

Any other interpretation will lead to warped practices by hospitals and physicians to game the system, substantial confusion over which patients are covered by EMTALA, disparate and discriminatory treatment of patients with the same emergency condition depending upon how they happened to enter the hospital, and still more regulatory and civil grief and liability for hospitals under the law. ■

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When are you liable for response to "code blues" on other units?

Risks are considerable, but lawsuits are uncommon

ED physicians responding to "code blue" alerts on inpatient units is a common practice — but one that exposes them to considerable legal risks. If the patient does not survive, there may be some question in the mind of the patient's family about whether the physician involved did something wrong, says **Robert B. Takla,** MD, FACEP, vice chief of the Emergency Center at St. John Hospital and Medical Center in Detroit.

"This increases the chance of being named in a lawsuit," says Takla. "Even if the ED physician did everything correct, they will be dragged into the legal process. And even if the physician is eventually dismissed, there is the investment of time and emotions to clear one's name."

Since the ED physician usually knows little about the patient in a code blue situation, there is a greater chance of error, says **Matthew Rice,** MD, JD, FACEP, an ED physician with Northwest Emergency Physicians of TEAMHealth in Federal Way, WA. "Since the situation is often confusing and occurring in less than an optimal environment, mistakes can occur," he says.

Often the "code team" is not experienced with codes and the equipment may not be present, correct in type, or may not function, adds Rice. "Thus, a difficult situation can become more difficult. And if the outcome is not good, the ED physician may be included in the 'blame game' of litigation," he says.

In addition to errors in airway management such as esophageal intubation, incorrect medications can lead to significant problems that may reflect poorly on the ED physician if litigation occurs, says Rice.

"Fortunately, it is unusual for ED physicians to be involved in inpatient code-related litigation," says Rice. "Such codes are often considered the best effort to save a life otherwise lost, and ED physician participation is often viewed in a favorable light."

Key Points

- Responding to "code blues" on other hospital units carries significant liability risks for emergency physicians. However, plaintiffs must prove the patient has a greater chance of surviving if the alleged malpractice had not occurred, and "Good Samaritan" laws may provide immunity from claims of negligence.
- If you or the hospital bills for your services, this negates your immunity.
- Immunity doesn't cover gross acts of negligence.
- Physicians could be liable for leaving an ED patient to respond to an inpatient code.

Will you be immune from a lawsuit?

In California, code blue teams receive statutory immunity through "Good Samaritan" protection, says **Jonathan D. Lawrence,** MD, JD, FACEP, an ED physician and medical staff risk management liaison at St. Mary Medical Center in Long Beach, CA. Lawrence has been an expert witness in cases involving ED physicians who have been sued after responding to codes on the floor.

"In every one of those cases, the plaintiff's attorney had to be educated about the immunity — a lot of them are not aware of it — and then the case against the ED physician was gone," says Lawrence.

In not billing a patient for resuscitative services, the ED physician may proffer a defense of being a "Good Samaritan" who was only trying to help. "However, if billing for services occurs for such codes, the argument of being a Good Samaritan is diminished," says Rice.

If you are an independent contractor and respond to codes outside of the ED and bill for your services, that will negate your immunity, says Lawrence. "If you are a hospital employee, and the hospital is charging on your behalf, it also negates your immunity," he says.

Also, Good Samaritan protection doesn't include gross acts of negligence. "But in the physician's favor is the fact that the plaintiff has to prove that had you done your job correctly, there was a greater than not likelihood that the patient would have survived. And that's simply not true for code statistics anywhere," says Lawrence.

Therefore, the plaintiff's attorney would have a very hard job proving that the patient's outcome would have been better if the alleged malpractice had not occurred, says Lawrence.

"Their best shot is somebody in ventricular fibrillation — those patients have the best chance of recover-

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SPECIAL REPORT

Liability Risks Vary in Emergency Physicians' Response to Code Blue Alerts

By William M. McDonnell, MD, JD, *Assistant Professor, Pediatric Emergency Medicine, Adjunct Professor, S.J. Quinney College of Law, University of Utah, Salt Lake City, member of the American Academy of Pediatrics National Committee on Medical Liability and Risk Management*

By nature of their training, skills, and in some hospitals, based on their job descriptions, emergency physicians often respond to hospital "Code Blue" alerts. Not surprisingly, many patients involved in Code Blue situations have poor outcomes, and patients or their families may elect to bring medical malpractice claims against the physicians involved in the resuscitation attempts. Emergency physicians' potential malpractice liability in such cases may be affected by several factors.

Good Samaritan Statutes

All states have enacted some form of Good Samaritan statute that is designed to encourage prompt emergency care by granting health care providers immunity from civil damages and removing the fear of liability. Generally, when an individual with no pre-existing duty to do so voluntarily provides emergency assistance to a victim, the volunteer is shielded from claims of negligence. However, there is wide variation in states' application of Good Samaritan protections to physicians.

Of primary importance in determining whether an emergency physician will be protected by a Good Samaritan law is whether the physician had an obligation to provide the emergency care. When the hospital's rules or the physician's job description require that the physician respond to the Code Blue, courts have found a pre-existing duty to provide the emergency care, and have determined that the physician is not a volunteer entitled to the protections of the Good Samaritan laws. In such cases, physicians may be held liable for any negligent care.

When the physician has no obligation to respond to the Code Blue, but rather does so as a volunteer, some states have provided Good Samaritan protection from claims of medical malpractice.[1] For example, in *Hirpa v. IHC Hospitals, Inc.,* an emergency physician responded to a Code Blue in the labor and delivery suite, and assumed control of the resuscitation at the request of the patient's obstetrician.[2] The Court noted that because the emergency physician had no "particular employment duty to aid the patient," Good Samaritan protection from malpractice claims was appropriate in order to "encourag[e] humanitarian acts by licensed medical providers."[3]

Other states, however, have determined that Good Samaritan immunity from malpractice claims is not available to emergency physicians treating individuals in a hospital. In Texas, Good Samaritan protection is not available to a physician in a hospital if he or she "regularly administers care in a hospital emergency room."[4] A number of states have determined that no Good Samaritan immunity is available to any physician providing care in a hospital, even without a pre-existing relationship to the patient or any obligation to provide such care.[5]

EMTALA Effects on Good Samaritan Immunity

The Emergency Medical Treatment and Labor Act (EMTALA) imposes a general obligation on emergency physicians to evaluate, and if necessary, stabilize all patients who present to the emergency department complaining of a medical condition.[6] As such, it establishes a duty on the part of the physician to the emergency department patient, and will generally eliminate any Good Samaritan immunity for care provided in the ED.

Rescue Team Statutes

California and Hawaii specifically shield from medical malpractice liability physicians who are part of the hospital's rescue teams, and those who are directed by hospital policies to respond to Code Blue activations.[7] In *Lowry v. Henry Mayo Newhall Memorial Hosp.,* the patient suffered a cardiac arrest while an inpatient at the hospital.[8] The defendant physician, a member of the hospital's Code Blue team responded to the patient's room, and allegedly departed from Advanced Cardiac Life Support (ACLS) guidelines in her choice of resuscitation medications. The California Court of Appeals rejected the plaintiff's malpractice and wrongful death claims, ruling that as a trained physician "designated by the health facility to attempt . . . to resuscitate persons who are in immediate danger of loss of life," the defendant was immune to claims of negligence.[9]

Minimizing the Risks

As in any other setting, emergency physicians providing care in

Code Blue situations should endeavor to provide care in accordance with prevailing practice standards and should appropriately document their care. They should understand their relevant state Good Samaritan laws. In states that allow Good Samaritan immunity for physicians providing volunteer emergency care in the hospital, emergency physicians will be well-served by clear hospital policies regarding Code Blue responses. Hospital policies and employment contracts that clearly state that emergency physicians are not required to respond to Code Blue alerts, but rather that they are encouraged to do so as volunteers, might allow Good Samaritan immunity to some emergency physicians. In states with rescue team immunity laws, on the other hand, physicians who respond to Code Blue alerts should be formally designated (and trained) as part of the hospital's rescue team. ■

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ing fully. But other than that circumstance, the recovery rates once someone goes into arrest are really dismal. So the plaintiff would not win on that basis," says Lawrence. "That is why these cases are fairly rare. However, juries have been known to not behave logically, and there is always that risk."

Don't abandon ED patients

There is another aspect that shouldn't be ignored, says Lawrence — the fact that the emergency physician's primary obligation is to patients in the ED. "So even if we are members of the team that responds to codes on the floor, if we have an equally critical patient in the ED, we can't leave that patient or we could be liable to that patient," says Lawrence.

Therefore, to protect ED patients and themselves from litigation, ED physicians should respond to in-hospital codes only when there is a life and death emergency, and only when there are not equal or greater emergencies in the ED at the same time, advises Rice.

When responding to a Code Blue, the ED physician should provide appropriate resuscitative care and then return to the ED as soon as possible, adds Rice. "Since in-patients have a provider of record, that provider should be contacted immediately and summoned to manage the patient while the ED physician returns to the ED," he says.

Contingency plans are needed in case the ED physician has a simultaneous code or critical situation in the ED, says Takla. This could involve floor nurses trained in Advanced Cardiac Life Support (ACLS), or CRNAs or respiratory therapists who can intubate patients, he says.

Takla is currently defending a case involving an ED physician at a community hospital who responded to a Code Blue outside of the ED. "She ran the code properly," says Takla. "What made this case so frustrating is that there was another physician on the unit when they called the code. The other physician did not get involved, and let the ED physician leave the ED and come to the unit to run the code."

Sources

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There is a trend of hospitals not supporting the actions of contracted physicians, notes Takla. "If the hospital can shift the area of concern to the physician's negligence or deviation in the standard of care, and can get the physician's policy to pay, they may try that strategy," he says.

For this reason, liability coverage should be stipulated when an ED physician responds to a code on the floor, says Takla. "The majority of emergency departments nationally are staffed by contracted groups rather than employed by the hospital," he says. "As such, liability coverage of codes outside the ED should be stipulated in the service contract and reviewed annually." ■

Long ED waits for psychiatric patients can lead to lawsuits

Claims of overcrowding won't get jury's sympathy

After waiting 22 hours to be transferred to another facility, a homeless man committed suicide in a Douglasville, GA, ED seclusion room. An investigation by the Centers for Medicare and Medicaid Services (CMS) found that the man had not been properly monitored by ED staff.

The incident puts a spotlight on the legal risks of psychiatric patients restrained or secluded for long periods in EDs — an increasingly common scenario. To reduce risks, do the following:

- **Use "sitters" to monitor patients in restraint or seclusion.**

Key Points

When psychiatric patients are held in EDs for extended periods, liability risks include patients harming themselves, leaving without being treated, or deteriorating.

- If the patient is evaluated by a non-physician after hours, the ED physician can be held liable if there is a bad outcome.
- If an admitted psychiatric patient is held in the ED, the ED physician may still bear legal responsibility for the patient.
- Document that risk was assessed and immediate steps taken to ensure patient safety.

This is the best way to prevent many adverse outcomes, says **Susan Stefan,** an attorney at the Newton, MA-based Center for Public Representation. Stefan is author of *Emergency Department Treatment of Psychiatric Patients: Policy Issues and Legal Requirements* (Oxford University Press, 2006).

"If a person is in dire enough straits to be in seclusion, he or she really should be monitored very regularly, if not constantly," she adds.

While the use of restraint and seclusion in psychiatric wards is closely regulated, EDs are much less regulated, even though staff usually have far less training and are at higher risk for inappropriately using restraints, notes Stefan.

National standards from CMS address monitoring obligations of patients who are in seclusion, including ED patients. "Those standards have unfortunately been weakened recently," says Stefan. Prior to December 2006, the condition of a patient in restraint or seclusion had to be "continually monitored," but now the condition must only be monitored "at intervals to be determined by hospital policy."

Your ED's policies should be consistent with current practice, advises **Sandra Schneider,** MD, professor of emergency medicine at University of Rochester. For example, if the policy says that all patients should be in a seclusion room with 1:1 sitter, but seclusion rooms are seldom available, and 1:1 sitters are not available in the ED, then the policy should be changed to reflect the reality of the ED.

- **Document your risk assessment and immediate steps taken to ensure patient safety.**

Despite the ED's best efforts, some patients will still find ways to harm themselves. "A well-documented chart that outlines the things that were done to prevent the harm is the best defense," says Schneider.

- **Hold patients who are at risk for self-harm against their will if necessary.**

"Patients should be held until their own ability to act in their own best interest is restored," says **Gregory Luke Larkin,** MD, MS, MSPH, FACEP, professor and associate chief of emergency medicine at Yale University School of Medicine in New Haven, CT. "This is one reason why it is important for EDs to be staffed with board-certified emergency physicians skilled in the ethical and efficient use of restraints, both physical and chemical."

Being sued for unlawful restraint or battery is far less likely to happen than being named in a lawsuit from an aggrieved family of a patient who left against medical advice and died, according to Larkin.

Documenting the risk of self-harm assures that the ED can place the patient in a secure situation, even against the patient's wishes. "This is the safest envi-

ronment for the patient, although it obviously doesn't always prevent a bad patient outcome," says **Thomas W. Lukens,** MD, PhD, FACEP, operations director for emergency medicine at MetroHealth Medical Center in Cleveland.

Long delays in waiting rooms are high risk

"Being kept in the waiting room creates a high-risk situation," says Lukens. "Unfortunately, this is all too common with psychiatric patients due to the lack of facilities to hospitalize and further evaluate such patients."

A lawsuit could certainly be filed if a patient harms him or herself in your ED waiting room, but the bigger question is whether it could be defended, says **Glenn Currier,** MD, associate professor of psychiatry and emergency medicine at the University of Rochester (NY) Medical Center. "If a patient is through the triage process, and an issue of suicide is uncovered, it's hard to think of a good reason to park them in the waiting room unmonitored to await assessment," says Currier.

Even if everything was done "right" by the ED, a suit is likely to be filed if a patient harms him or herself. "Lawsuits can be brought forward based on the outcome, not just the treatment," Currier says. "It is then up to the ED to prove they acted within a reasonable standard of care."

Don't expect that lack of available inpatient psychiatric beds and a crowded waiting room will get a jury's sympathy. "The defense that the ED was too crowded could reasonably be used, but I don't think it would amount to anything at a trial," says Lukens. "Patient safety is the overriding issue, and needs to be maintained regardless of the volume."

System overload can certainly be used as a defense, but it's not likely to absolve the emergency physician and hospital of liability, however legitimate the claim. "EDs and the physicians therein may be sued for anything they do or don't do, so long as there are damages and a willing attorney to take the case," says Larkin.

Waits dangerous for many reasons

There are significant liability risks when *any* patient waits for hours in the ED, says Schneider. "Wait times have been the subject of news stories, and the public reacts with disdain as if the waits are caused by the providers being lazy," she says. "They don't understand that our spaces and our staff are caring for inpatients that cannot be placed in inpatient beds."

When patients wait to be seen, they become angry and frustrated, which is compounded for a patient with poor coping skills or a distorted reality due to mental illness, says Schneider. "Not only is there significant liability, there is also potential for injury to the staff."

Schneider says she knows of several instances where significant harm was done to ED staff by frustrated psychiatric patients who were kept waiting for hours. "Patients with medical conditions that deteriorate are usually, though not always, detected by the triage nurse. Those with mental illness are less obvious," she says.

If a patient with chest pain gets frustrated with the wait and wants to leave, the staff will rapidly try to stop him or her. "But unless a patient is suicidal or homicidal, the staff may actually be relieved when a mentally ill patient decides to leave," says Schneider. "However, the ED still can be, and has been, sued for any harm that comes to the patient." For example, if a mentally ill patient leaves the waiting room and is hit by a car while walking home, the ED could be held liable.

If psychiatric patients are mixed with medical patients, they may leave without being noticed. "Some ED's give 'flight risk' patients a different color gown or booties and secure their regular clothing," says Schneider. "The entire staff then can detect a patient who is leaving the premises."

Anywhere from 8% to 12% of non-psychiatric ED patients harbor thoughts of self harm without disclosing this, according to a 2005 study. Of 1590 patients screened, 31 reported planning suicide, and 25 of these went undetected during their ED visit. Of this group, four attempted suicide within 45 days of the ED visit (all survived).[1]

"Indeed, we found at a major urban trauma center that 1-2% of ED patients have a plan to harm themselves, but we completely missed the majority of them as we do not screen for suicidal ideation on any routine basis," says Larkin, who co-authored the study.

Therefore, any patient who leaves your ED without being treated is a potential victim of suicide, and a potential plaintiff. "ED physicians are currently being asked to screen for over a dozen risks from latex allergies and tetanus to smoking and partner violence, but suicide, despite its gravity, hasn't yet made the screening list," says Larkin.

Who will be liable?

Mentally ill patients who harm themselves while waiting in the ED can clearly sue the hospital, but once the patient is actually seen, the process "gets

even muddier," says Schneider. In many facilities, after-hours evaluations are performed by a non-physician, such as a psychiatric social worker or psychologist.

"The training and supervision is usually not from the ED. Most of them are in fact excellent clinicians," says Schneider. "However, their evaluation is in essence advisory to the physician. The ED physician can clearly be liable if there is a bad outcome — for example, if a patient commits suicide after being cleared by a mental health worker."

Since the ED physician often writes the prescription for any medications recommended by the mental health worker, the doctor-patient relationship is established, Schneider says.

When an admitted psychiatric patient is held in the ED, a different legal issue can ensue. The admitting physician is not in the ED and may have never have seen the patient, whereas the ED physician remains in proximity and has seen the patient.

"Legally, it is not always clear which of the physicians bears the responsibility for the patient," says Schneider. "Once the patient has been seen and a note is written by the admitting physician, things are a little clearer — but there is still room to sue the ED doctor."

Sources

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Patients may deteriorate

ED policies, practices, and conditions can exacerbate a patient's psychiatric condition or cause it to deteriorate, warns Stefan.

"If a person seeks help in an emergency department because of severe depression and emotional distress and is contemplating suicide, a long, solitary wait in a small ED cubicle is probably not going to help," she says.

Many EDs require patients to remove their clothing, which could cause severe distress for psychiatric patients who have sexual abuse histories. "Some EDs then forcibly restrain and strip these psychiatric patients who are, at this point, in much worse psychiatric condition than when they arrived," Stefan says.

Stefan currently represents a Boston woman who is suing an ED nurse and hospital for this practice, which is still in active litigation. She also notes that a previous case involving this scenario was settled for an undisclosed amount after the court found that the plaintiff could proceed with her discrimination and negligence claims.[2,3]

Stefan says she doesn't think litigation against EDs is likely to be about wait times of psychiatric patients. "It's far more likely to be about restraint, such as physical restraint involved in forcible clothing removal," she says. "Also, a significant number of EDs are sued because of physical force used by security guards."

Juries are more likely to be sympathetic to claims of medical conditions that deteriorated in ED waiting rooms, such as a heart attack, rather than a more intangible psychiatric condition, says Stefan.

"Nevertheless, I think juries might be able to understand how hours and hours of unending and unfamiliar noise, lights, chaos, and hubbub of an ED might exacerbate someone's psychosis, or how the long hours in a lonely little room with no one to talk to might make a depressed person more suicidal," she says.

References

1. Claassen CA, Larkin GL. Occult suicidality in an emergency department population. *Br J Psychiatry* 2005;186:352-353.
2. *Sampson v. Beth Israel Deaconess Medical Center,* No. 06-CV-10973-DPW (D. Mass. filed June 5, 2006).
3. *Scherer v. Waterbury,* No. CV-97-0137073 (Waterbury Sup. Ct. filed Dec. 9, 1996).

CNE/CME *Questions*

24. According to the enclosed article, the elements of CMS's new proposed requirement that hospitals must accept appropriate transfers of inpatients include which of the following?
    A. The individual must have presented to the hospital under EMTALA.
    B. The hospital must determine that the individual has an emergency medical condition (EMC) that is unstabilized.
    C. The individual must be admitted to the hospital and the individual's EMC must have remained unstable since the time of admission;
    D. The hospital must be unable to stabilize the EMC and the receiving facility has the capacity and capability to treat the patient's EMC.
    E. All of the above.

25. Which is true regarding immunity for an ED physician's response to a "code blue" on another hospital unit?
    A. If an ED physician is an independent contractor and bills for his/her services, this would have no impact on Good Samaritan protections.
    B. If the ED physician is a hospital employee and the hospital charges for his/her services on the physician's behalf, this would not negate the ED physician's Good Samaritan protection.
    C. Under Good Samaritan protection, ED physicians are immune even for gross acts of negligence.
    D. If a malpractice suit is filed, the plaintiff must prove the probability that a better outcome would have occurred had the alleged malpractice not occurred.

26. Which is recommended to reduce the liability risks of responding to codes outside of the ED?
    A. The provider of record should be contacted immediately to manage the patient.
    B. The inpatient provider should not be contacted immediately after the code.
    C. ED physicians always should respond to all in-hospital codes, regardless of whether it is a life and death emergency.
    D. ED physicians must respond to in-hospital codes even if there are equal or greater emergencies in the ED.

27. Under which scenario is the ED physician potentially liable for a psychiatric patient's adverse outcome?
    A. When the patient is being held in the ED while waiting for an inpatient bed.
    B. If the patient is admitted, but has not yet been seen by the admitting physician.
    C. If the patient has been seen by the admitting physician but is still in the ED.
    D. All of the above

28. Which is true regarding liability risks if a patient commits suicide after being cleared by a mental health worker after hours in the ED?
    A. The ED physician is not liable for any adverse outcomes that occur after the mental health worker's evaluation is completed.
    B. If the ED physician writes the prescription for medications recommended by the mental health worker, the doctor-patient relationship is established and the ED physician could be held liable.
    C. The ED physician is only exposed to legal risk if the mental health worker's evaluation is not appropriately documented.
    D. As long as the evaluation is done by a non-physician, the ED physician is not liable.

Answers: 24. E; 25. D; 26. A; 27. D; 28. B

CNE/CME Objectives

After completing this activity, participants will be able to:

1. Identify legal issues relating to emergency medicine practice;
2. Explain how these issues affect nurses, physicians, legal counsel, management, and patients.
3. Integrate practical solutions to reduce risk into the ED practitioner's daily practices. ■

CNE/CME instructions

Physicians and nurses participate in this CE/CME program by reading the issue, using the references for research, and studying the questions. Participants should select what they believe to be the correct answers, then refer to the answer key to test their knowledge. To clarify confusion on any questions answered incorrectly, consult the source material. After completing the semester's activity, you must complete the evaluation form provided and return it in the reply envelope to receive a letter of credit. When your evaluation is received, a letter of credit will be mailed to you. ■