CHAPTER 202

Medicolegal Issues and Risk Management

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PERSPECTIVE

Practicing good medicine in the emergency department (ED) may have been enough to avoid legal entanglements historically, but no longer. Federal and state laws now directly govern the practice of emergency medicine. The magnitude and complexity of the controlling legal authority, plus the significant penalties for noncompliance such as criminal sanctions, civil lawsuits, civil monetary penalties, or exclusion from participation in Medicare and Medicaid, dictate that emergency physicians acquire functional knowledge of these laws.

Federal law, the Emergency Medical Treatment and Active Labor Act (EMTALA), (a section of the Consolidated Omnibus Budget Reconciliation Act of 1985 [COBRA]), also known as the "antidumping" statute, governs how emergency physicians must triage, register, examine, provide workup, treat or stabilize, discharge or transfer, utilize hospital resources, and involve medical staff expertise when caring for patients presenting to the ED.[1-3] State laws further control the practice of emergency medicine through such issues as consent, reporting requirements, confidentiality requirements, forensic and police matters, civil commitments, and emergency medical services (EMS) statutes.

EMERGENCY MEDICAL TREATMENT AND ACTIVE LABOR ACT

EMTALA originally was enacted to prevent private hospitals from transferring ("dumping") medically unstable, indigent patients to public hospitals. Subsequent amendments to the law, government regulations, and court decisions greatly expanded the reach of EMTALA, such that the law now sets national standards of care for emergency services.[2-4] Today's practice of emergency medicine requires a firm understanding of EMTALA's statutory requirements and how the regulatory agencies and the courts interpret the three main aspects of the law: screening, stabilizing, and discharging or transferring ED patients.

Medical Screening Examination

Any person who comes to an ED requesting examination or treatment must be provided with an appropriate *medical screening examination* (MSE).[5] The purpose of the MSE is to determine whether the patient has an *emergency medical condition* (EMC).[6,7]

Emergency Medical Condition

The EMTALA defines an EMC as "acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in any of the following: (1) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (2) serious impairment to bodily functions, or (3) serious dysfunction of any bodily organ or part."[6] In the case of a pregnant woman who is having contractions, an EMC is defined as one in which "[t]here is inadequate time to effect a safe transfer to another hospital before delivery, or the transfer may pose a threat to the health or safety of the woman or the unborn child."[7]

Competent physicians can reasonably disagree whether certain conditions are serious enough to constitute an "emergency." However, the courts hold that the relevant factor is whether the physician *perceived* the patient to have an EMC, not whether the patient actually had an EMC, and not whether the emergency physician or hospital should have known that the EMC existed. The focus is whether the physician or the hospital in fact *actually determines* that the patient has an EMC; the standard is subjective, not objective.[8] If the physician and the hospital perform an appropriate MSE and in good faith determine that no EMC exists, the courts will not retrospectively review that decision; rather, it will be a simple state malpractice issue of whether the examination and diagnosis met the applicable standard of care.

If the MSE does not reveal an EMC, further care of that patient is not controlled by EMTALA, so the law's provisions governing stabilizing treatment, transfer of the patient, or involvement of on-call physicians no longer apply. This interpretation emphasizes the critical importance of documentation of the presence or absence of an EMC during a patient's initial ED evaluation. A checkbox to indicate such should be on every ED medical record.

"Any Individual"

Everyone who presents to the ED requesting care must be screened. Whether the patient is indigent, a member of a managed care plan, or covered by Medicare, Medicaid, or private insurance is irrelevant; the hospital must provide everyone who presents for care with an MSE.[5] This includes all patient populations, such as illegal aliens, minors, and

private patients of the hospital's medical staff but excludes persons who are already patients of the hospital, such as inpatients or outpatients undergoing a scheduled procedure at the hospital who are brought to the ED for emergency care.[2] The screening of minors is discussed later in the section on consent.

Private Patients

In many hospitals, members of the hospital's medical staff often meet their private patients in the ED. These patients are examined and treated by their private physicians, not the emergency physician on duty. Such practice is entirely appropriate to maintain physician-patient relationships and is allowable under EMTALA. However, the hospital should have prearranged procedures for handling private patients that do not unduly delay the patient's MSE; otherwise, the hospital could be liable under EMTALA for failure to provide an "appropriate" MSE. Delay of treatment in such instances also frequently results in hospital liability through state malpractice actions.

All private patients should be triaged according to the hospital's established protocols. If the triage nurse determines that the patient requires immediate care, the emergency physician on duty should provide the necessary treatment until the patient's private physician arrives in the ED to assume the patient's care.

If triage determines that the patient does not require immediate care, the emergency physician should see the patient in the order consistent with the usual practice of the ED, generally in the order of acuity or time of arrival. If the private physician comes to the ED and sees the patient before the emergency physician does, the examination by the private physician constitutes the required MSE by the hospital. In this situation, no undue delay of the MSE for any nonmedical reason has occurred. However, if the patient's private physician has not arrived by the time the emergency physician would normally examine the patient, the emergency physician should perform an MSE. If no EMC is evident, the patient can wait for his or her physician to arrive. If an EMC exists, the emergency physician should undertake appropriate stabilizing treatment until the patient's physician arrives.[9,10]

"Comes to the Emergency Department"

The Centers for Medicare and Medicaid Services (CMS) (formerly the Health Care Financing Administration [HCFA]) deems anyone on hospital property to have "come to the emergency department."[11,12] According to CMS, "hospital property" consists of the entire main hospital campus, including parking lots, sidewalks, and driveways, and any ambulance owned and operated by the hospital, even if the ambulance is not on hospital grounds.[11] CMS then divides hospital property into "dedicated emergency departments" and all other property that is not a dedicated ED.

A *dedicated* ED is defined as any department or facility of the hospital, whether on or off campus, that is licensed by the state as an ED; is held out to the public as a place that provides care for persons with EMCs on an unscheduled basis; or actually does provide care for persons with EMCs a certain percentage of the time.[2] Units qualifying as dedicated EDs include typical hospital EDs, labor and delivery units, and psychiatric intake centers.

CMS also intended EMTALA to apply to urgent care centers. However, urgent care centers do not hold themselves out as able to provide care for EMCs as defined by the statute, nor do they in actuality provide care for a sufficient number of true emergencies to meet the regulatory percentage. Thus, the typical urgent care center is not likely to meet the new regulatory definition of a dedicated ED and therefore will not have to comply with EMTALA. CMS may readdress this issue in the future. Hospitals should examine how their relationship with any urgent care centers is legally structured in conjunction with the new regulations to determine whether EMTALA applies.[2,13]

CMS specifically exempts a number of on-campus areas from compliance with EMTALA—generally, those areas that typically do not provide emergency care, such as physicians' offices, skilled nursing facilities, other entities that participate separately under Medicare, and other nonmedical facilities on campus.[2] CMS also exempts application of the law to off-campus facilities and other "departments of a provider" that were never intended or structured to manage EMCs, such as dialysis centers, rehabilitation units, laboratories and radiology centers, or primary care clinics. These facilities must have, however, written policy and procedures for appraisal of emergencies and arranging transfers when appropriate.[14,15]

Presentations to the hospital's dedicated ED require only a request for examination or treatment of a medical condition; it is not required that the presentation be for a medical condition that constitutes a true emergency to trigger EMTALA's screening duty. Presentations to hospital property other than the dedicated ED do, however, require the request to be for an EMC before EMTALA applies.[2]

"Parking" of Patients Brought by Emergency Medical Services to the ED

Overcrowding led some hospitals to ignore ambulance patients and leave EMS to care for them until the hospital "accepted" the patient, a practice termed "EMS parking." These hospitals erroneously believed that unless they accepted responsibility for the patient, they had no EMTALA duty to provide care or accommodate that patient. CMS issued a memorandum reminding hospitals that their EMTALA obligation begins the moment the patient "comes to the ED" and a request is made on behalf of the patient for examination or treatment of a medical condition, not when the hospital "accepts" the patient.[16] (Of note, the practice of "parking" EMS patients also may violate Medicare regulations, which require hospitals to "meet the emergency needs of patients in accordance with acceptable standards of practice."[17])

Subsequently, EMS organizations cited the CMS memo as requiring hospitals to take instant custody and responsibility of all patients brought in by EMS. In response, CMS issued a clarification to its "parking" memo, stating that its guidance "should not be interpreted to mean that a hospital cannot ever ask EMS personnel to stay with the person they transported to the ED when the hospital does not have the capacity or capability to immediately assume full responsibility for the individual."[18] Also pointed out was that in certain circumstances, such as an influx of multiple trauma victims, it would be reasonable for the hospital to ask the EMS provider to stay with the patient until such time as the ED staff became available to care for that person.

CMS did note, however, that "even if a hospital cannot immediately provide an MSE, it must still triage the individual's condition immediately upon arrival to ensure that an emergent intervention is not required and that the EMS provider staff can appropriately monitor the individual's condition."

CMS will review complaints of this nature on a case-by-case basis to determine if the hospital violated EMTALA's medical screening mandate.[18]

National Emergencies or Disasters

Under certain circumstances, the Secretary of Health and Human Services can exempt hospitals from EMTALA during times of national or local disasters or terrorist acts, bioterrorist events, or pandemic infectious disease.[19,20]

Request for Examination or Treatment of a Medical Condition

Mere presence in the ED or on hospital property is not sufficient to trigger the hospital's duty to provide an MSE; a request for examination or treatment also is necessary. The request can be made by *anyone* on behalf of the patient, including EMS personnel, a police officer, or a babysitter; the request does not have to come from the patient, a family member, or a legal guardian.[5]

Also, if a person is unable to speak to request care, that person's behavior may constitute a request if the hospital's personnel are aware of the behavior and a prudent layperson would believe that the behavior indicated a need for examination or treatment.[2]

Other Emergency Department Functions

Hospital EDs serve many functions other than the evaluation and treatment of patients with true medical emergencies. Physicians on the hospital staff may use the ED in the off-hour periods to provide injections or obtain laboratory tests or radiographs on their patients. Police use the ED to obtain blood alcohol samples on allegedly intoxicated automobile drivers. Some hospitals may use the ED to provide urine drug screens on injured workers, prescription refills, allergy shots, rabies vaccinations, blood transfusions, or other community medical services such as blood pressure screening or flu shots.

Laboratory Tests and Radiography Requests

The test category includes urine or serum drug screening, routine laboratory tests, and imaging studies. In each case, no immediate medical decision making is required. The patient's physician determines the indication for the studies and is responsible for the patient's care, including following up on the test or radiography results. The patient is not requesting "examination or treatment for a medical condition" by the hospital's ED, so the hospital does not need to provide an MSE.

Such patients should not be sent through triage and should not have their vital signs taken, and the hospital should not create the usual ED chart for them. They should not be asked to sign the usual ED "consent for treatment" forms, which could imply they were requesting examination and treatment. Separate paperwork should be used to document the visit, the particular test performed, the patient's informed consent for the testing, any communication with the private physician, and a specific statement that the patient is not requesting an MSE from the ED, with the patient's signature.

Some persons come to the ED on their own, not at the request of their physician, and request a test (e.g., for pregnancy or human immunodeficiency virus serostatus). All such persons should be given an MSE before any test is conducted. If the person declines the MSE, he or she should be referred elsewhere to obtain the requested test: outpatient clinic, personal physician, or public health clinic, or a local drugstore for a pregnancy test. Documentation that the person declined the offered MSE is essential.

Minor Treatments

The minor treatment category includes allergy shots, tetanus shots, rabies vaccines, bloodletting or blood transfusions, chemotherapy infusion for cancer or possible organ transplant rejection, reinsertion of a feeding tube or Foley catheter, prescription refills, suture removals, antibiotic injections, and narcotic injections for chronic pain syndromes. Patients presenting to the ED requesting treatment should be given an MSE. In each instance, the common denominator is the element of medical decision-making.

Antibiotic and narcotic injections require special comment. Physicians, particularly in rural hospitals, send their patients to the ED and then call in phone orders for parenteral medications. The patients are not examined by the emergency physician on duty. This practice should be avoided, and it probably violates EMTALA because the hospital does not provide the patient the same MSE as for any patient with the same complaint. It is irrelevant if the patient's private physician performed an office examination immediately before sending the patient to the ED. This requirement of EMTALA may not be cost-efficient medicine, but both CMS and the courts agree that the hospital must provide an MSE to any person who comes to the ED and requests examination or treatment for a medical condition.[1,21]

All patients presenting for minor treatments should be triaged, registered, and managed as for all other ED patients. The ED evaluation should determine whether the patient's condition meets the definition of an EMC before the hospital administers any medications. CMS and the courts will assume that these patients requested examination or treatment, and the hospital must demonstrate that either (1) these patients did not request that an MSE be performed or (2) the ED evaluation did not reveal an EMC.

CMS recently attempted to eliminate application of EMTALA to persons coming to the ED for reasons other than seeking emergency care. However, the language of the new regulations really did not change anything. The hospital still must perform an MSE of an extent necessary to determine whether an EMC exists, regardless of whether the patient's presenting complaint appears to be for a "nonemergency" condition.[2,13]

Prescriptions

In small communities, local pharmacies frequently are not open continuously. Hospital pharmacies, sometimes through the hospital ED, fill prescriptions for patients in off-hours. Patients presenting to the ED to fill these prescriptions do not need an MSE. If the prescription is filled through the ED, the hospital should have the patients sign a form indicating they are not requesting an MSE, for the same reasons and in the same manner as when tests are done in the ED at the request of physicians.

This situation is different from that in which patients present to the ED for prescription renewals. Patients requesting "refills" on this basis are seeking not pharmacy services but medical decision-making services from a physician by asking for a prescription renewal to treat an underlying medical condition.[2,9] Therefore, patients seeking prescription *renewals* must be provided with an MSE.

Sexual Assault Cases

The ED often assists police in the collection of evidence related to alleged sexual assault cases. If a person comes to the ED solely to provide evidence for the criminal investigation

and is not requesting examination or treatment for a medical condition, no MSE is required. However, if the person complains of pain or injury or wants pregnancy or sexually transmitted disease prophylaxis, that person is requesting examination or treatment for a medical condition and must be provided with an MSE.[22]

Preventive Services

Blood pressure screening and vaccination services do not require an MSE. The patient receiving such services is not requesting examination or treatment for a medical condition. The patient is attempting to prevent illness prophylactically, not seeking treatment of an illness. These vaccinations are distinct from tetanus boosters, because boosters typically are administered in response to injury and represent a component of medical decision-making and treatment.

Police Blood Alcohol Tests

For both medical and legal reasons, an MSE should be offered to all persons presenting to the ED for police-requested blood alcohol samples.[23] This scenario is different from that in which patients present to the ED to have blood tests done as ordered by their physicians. Persons in police custody have not been examined by a physician, and the results of the test will not be returned to a physician to care for the patient. The police officer brought the patient because of aberrant behavior, suspected to be caused by alcohol intoxication. Many diseases mimic alcohol intoxication, including hypoglycemia, cerebral hypoxia, head injury, metabolic abnormalities, and other toxins. Medically, alcohol intoxication should not automatically be presumed as the cause of the patient's condition merely because it is so common. The emergency physician should examine the person in custody to determine if an EMC exists.[9]

The patient may refuse the MSE and request that only the blood be drawn. If the patient appears competent, this can be done. The refusal of the MSE must be documented, as noted for other testing done in the ED, with additional documentation of the risks and benefits of the offered MSE and careful notation of the patient's competence. If the patient is too intoxicated to make medical decisions, release from the ED should be delayed until the patient is competent enough to make rational decisions. Only physicians should assess and document a patient's competence; other ED personnel should not be allowed to make these decisions.[9]

Again, under EMTALA, the "request for examination or treatment" can be made by anyone on behalf of the patient. The police officer's request for blood alcohol sampling may be sufficient to constitute the request for an MSE.

Direct Admissions through the Emergency Department

Direct patient admissions are always problematic. In the three most common scenarios, the patient (1) is sent to the ED after being examined by the primary care physician in the office, (2) is sent in after phone contact with the physician, or (3) is accepted by phone-in transfer from a different hospital ED or inpatient setting. In all three cases, the patient's physician intends to see the patient after admission to the inpatient setting, rather than in the ED. Medically, each presentation may require a different level of acute intervention, but legally all are the same under EMTALA.[2,3,13] CMS does not apply the law to *inpatients* regardless of whether they are directly admitted to the floor, directly admitted by way of the ED, or "boarded" in the ED awaiting bed placement. Even if the inpatient is brought down to the ED, the law does not apply.[2,24]

An *inpatient* is defined as "an individual who is admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services…with the expectation that he or she will remain at least overnight."[2] It does not matter if the situation changes later and the patient can be discharged or transferred to another hospital and does not actually use the bed overnight. The key element is that the patient must be formally admitted with a documented admission order. A physician's intent to admit or a level of acuity indicating that the patient "obviously will be admitted" is not enough to satisfy the definition. Documentation is critical.[2,24]

CMS does not consider patients admitted to observation status to meet the regulatory definition of admitted patients (not admitted for purposes of receiving inpatient services), so EMTALA still applies to the care of observation patients, such as patients managed in ED chest pain units.[2,24]

Therefore, under existing regulations, persons who were directly admitted and sent through or held in the ED from a physician's office, a nursing home, or in transfer from another ED or another hospital inpatient setting are no longer covered by EMTALA, even though they have "come to the hospital's emergency department."

Health Care Providers Qualified to Do the Medical Screening Examination

EMTALA does not specify whether a physician, a nurse, or another health care provider must perform the MSE. CMS regulations require that the screening examination be done by "qualified medical personnel,"[24] and that the hospital's governing body formally designate, in writing, who is a qualified person to perform medical screening on behalf of the hospital.[25,26] CMS specifies that the hospital cannot allow the medical director of its ED to designate who is qualified to perform screenings on behalf of the hospital.[27]

Triage by a nurse is not considered to constitute an MSE. Neither CMS nor the courts accept triage as adequate to determine whether an EMC exists.[2,9]

It is strongly recommended that hospitals designate physicians to be primarily responsible for MSEs performed in the ED. Either the physician personally performs the screening or is directly responsible for examinations performed by physician assistants or house staff. It is appropriate to use physician assistants and nurse practitioners to screen patients who are determined by nurse triage to have less acute or severe conditions. However, the physician on duty should have a direct supervisory role with the physician assistant and a collaborative arrangement with a nurse practitioner—the difference being that nurse practitioners have an independent state license, whereas the physician assistant functions under the license of the physician.

Ancillary Services as Part of the Medical Screening Exam

The law requires hospitals to provide the screening examination "within the capabilities of the hospital's emergency department, including ancillary services routinely available to the emergency department."[5] According to CMS, this means that the scope of an MSE may "range from a simple process involving only a brief history and physical examination to a complex process that also involves performing ancillary studies and procedures such as (but not limited to) lumbar punctures, clinical laboratory tests, computed tomography scans, diagnostic tests and procedures."[28]

Because the stated purpose of the MSE is to determine whether an EMC exists, CMS and the federal courts hold that the hospital must conduct whatever examination is necessary to make that determination.[3,29] It may take only a visual glance to rule out any EMC in a patient with a rash. However, if it takes a complete neurologic examination, computed tomography scan, and lumbar puncture to decide whether that patient has a serious underlying infection, then those procedures are considered part of the MSE.

Thus, if the ED usually has ultrasonography, computed tomography, ventilation-perfusion scans, and similar tests available, it must use those resources if necessary to determine whether the patient has an EMC. However, the hospital is obligated only to utilize the resources ordinarily available to its ED.[5] Neither the statute nor the regulations mandate that hospitals expand resources or offer additional services to ED patients. An exception may be the use of interpreters for patients not fluent in the English language, which is required by the Medicare conditions of participation.[30,31]

CMS views the ancillary services available to the ED as including the services of on-call physicians if their expertise is required to decide if the patient has an EMC.[2,9,13,28,30,32] If the emergency physician cannot determine whether a patient has an EMC, the physician must use the on-call physician services to help make that determination. For example, if it takes an on-call surgeon to decide whether a patient has an "acute abdomen," the surgical evaluation becomes an integral part of the hospital's MSE.

Policies, Procedures, and Practice Guidelines

The federal courts hold that an appropriate MSE has two components: (1) the examination must be "reasonably calculated to identify critical medical conditions," and (2) the "exact same level of screening must be uniformly provided to all patients who present with substantially similar complaints."[29] In other words, a hospital satisfies the requirements of EMTALA if it conducts standard screening procedures, uniformly, to all patients with similar complaints and circumstances.

Each hospital determines its own standard screening policies and procedures. By necessity, each hospital's standard will be individualized, because each hospital ED has its own capabilities and different ancillary services available. Once a hospital defines its standard screening process, however, it must apply that process uniformly to all patients presenting with similar complaints, and material departure from its standard screening procedure constitutes inappropriate screening under EMTALA. Because motive is not a relevant issue in the federal courts (except the 6th Circuit Court) or during CMS investigations, liability may result from any material deviation of the hospital's screening process, regardless of the hospital's motive and regardless of the reason for the deviation. For example, a Florida hospital's screening policy stated that triage would be conducted within 3 minutes after a patient's arrival at the ED. In one instance, a patient was not triaged until 45 minutes after arrival; this delay constituted a violation of the law because the hospital did not follow its own policy.[9]

Once hospitals define their own standard screening process, they will be held to that standard, by both plaintiffs and the government enforcers. Investigators and plaintiff attorneys will subpoena and closely examine the hospital's policies and procedures, medical staff bylaws, ED rules and regulations, practice guidelines, and other written information on the screening process. They will compare the written process to what actually transpired. These hospital documents must be drafted very carefully to avoid unintended liability.

Practice guidelines or protocols, including managed care manuals, adopted by EDs or hospitals may be treated essentially the same as the hospital's own policies and procedures. They also are routinely used to demonstrate that the hospital "failed to follow its own rules" when hospitals and physicians do not adhere to their adopted parameters. In fact, practice guidelines are used *against* physicians and hospitals much more frequently than they are used to their benefit in malpractice litigation.[33]

Registration Process, Collections or Insurance Information, and Authorization

CMS does allow hospitals to conduct reasonable registration procedures in the ED, including collecting insurance data or cash at the time of registration, as long as the process does not delay the MSE. A reasonable registration process may include obtaining demographic data, the name of the patient's physician, and determining whether the patient is insured and the type of insurance. During the registration process, the patient can sign the hospital's usual "informed consent to be examined" form and a routine form that holds the patient financially accountable for any charges not covered by the patient's insurance carrier.[2]

The key is to create parallel tracks for medical and financial issues and to ensure that the financial track never interferes with the medical care in any way. "Bedside registration" probably is necessary under the existing regulatory scheme to avoid "no-delay" violations, because CMS would consider any delay in access to the MSE due to diversion to the registration area to be against the law. Waiting for examination and treatment because the ED is overwhelmed is not a violation, but waiting for examination because the registration clerks are collecting insurance information may be.[2]

CMS warns hospitals not to coerce patients into leaving before they receive their federally guaranteed MSE, stating "reasonable registration processes may not unduly discourage individuals from remaining for further evaluation."[2]

Collection of copayments, down payments, advanced beneficiary notifications (ABNs), or signatures on managed care financial forms may constitute such "economic coercion" if not done very carefully. Hospitals also must ensure that staff behavior does not create a hostile environment or constructive denial of the MSE.

Furthermore, hospitals should never delay a patient's MSE in order to obtain prior authorization from a managed care organization (MCO). First, managed care authorization is authorization for payment only—it is not authorization for treatment; and second, CMS explicitly bans prior authorization for managed care plans before completion of the MSE and commencement of stabilizing treatment.[2] Hospitals may obtain authorization for payment from insurance entities only "concurrently" with stabilization of the patient.[2,27] Hospitals are legally obligated to provide the MSE, and they will be held to that standard regardless of the financial pressures placed on them by MCOs. (As a related issue, "[m]anaged healthcare plans cannot deny a hospital permission to examine or treat their enrollees. They may only state what they will and will not pay for, and regardless of whether a hospital is to be reimbursed for the treatment, it is obligated to provide the services specified in EMTALA."[27])

Patients often ask questions about their obligation to pay for emergency services, particularly whether their insurance will cover the visit or how much it will cost to receive care at the ED. Regardless of EMTALA, all patient questions should be answered forthrightly, honestly, and completely by the hospital staff. Generally, routine financial questions can be answered

by registration personnel or triage nurses trained to give "stock answers," to not discourage or coerce the patient in any way, and to encourage the patient to stay, with discussions of payment deferred until after an MSE is performed.

After the hospital answers the patient's questions, the patient is responsible for making informed decisions about further aspects of care. If a patient chooses to withdraw a request for examination or treatment and leave the ED, hospitals must carefully handle the interaction related to the patient's "voluntary withdrawal" (see the later section on consent). Whenever the patient intends to leave, the staff should involve the physician on duty.

Regardless of managed care status, "VIP" status, private patient status, or any other classification, all patients should be processed in the same manner.[34,35]

Additionally, the triage team, physician and nursing staff, and all clinical personnel should not know the patient's insurance status throughout the initial screening and stabilizing treatment. This removes insurance status as an issue should the government later claim that the staff was motivated in some way or treated the patient disparately on the basis of financial class. It is easier to prove that actions were not predicated on the patient's financial status when the actor lacks knowledge of that status than to prove that the actions were medically appropriate despite knowledge that the patient had no insurance.

After the MSE and initiation of stabilizing treatment, insurance status and ability to pay can be considered in determining the patient's future care, such as hospital admission, transfer, or discharge and follow-up.

Documentation

EMTALA is a technical law, and compliance with the technicalities requires proper documentation. Furthermore, clinical outcomes are irrelevant under government enforcement, and compliance is not presumed; the hospitals must prove compliance through documentation.

Central Log

Hospitals must maintain a central log of all patients presenting to the ED requesting examination or treatment. The log must contain the name and disposition of the patient, including whether the patient refused treatment, whether the hospital refused to provide an MSE or treatment, and whether the patient was admitted, treated and stabilized, transferred, or discharged.[36] The purpose of the log is to permit CMS and the state surveyors to select and review individual records to investigate whether the hospital is in compliance with the law.[28]

The log must include all persons presenting to the hospital's dedicated EDs, whether on or off campus.[2,36,37] These areas include the typical ED, freestanding emergency centers, labor and delivery suites, ambulatory care or fast track areas contained in the ED, and psychiatric intake centers.[2] The logs are not required to be collated into a single document but must be retrievable at CMS's request.

Medical Record

All areas of the hospital used to conduct the MSE must create a medical record for the patient and keep a log of those presenting for examination and treatment.[38] If members of the hospital medical staff see their patients in the ED, either on a scheduled or an unscheduled basis, the hospital must create a medical record and require the physician to document the care provided in that record. The physician's private office records documenting care provided at the hospital are insufficient.

Most important, the emergency physician should document whether an EMC was determined to exist on *every* patient seen in the ED, even if the initial chief complaint is seemingly trivial. The legal purpose of the required MSE is to determine if an EMC is present. To facilitate documentation, ED charts should include two check boxes: one labeled "EMTALA EMC present" and the other "EMTALA EMC absent." The person performing the MSE should check the appropriate box for each patient, and completion of this documentation should be a prime part of the ED's quality improvement monitoring program.

Stabilization Requirements

Once the hospital determines that an individual has an EMC, EMTALA requires the hospital to either stabilize the EMC or, if it lacks the capability to stabilize the patient, to transfer the patient to another medical facility that can provide the necessary treatment.[39] (A sample form for use in documenting such transfers and patient consent to transfer is shown in Figure 202-1.)

When and if the patient is "stabilized" has significant ramifications for hospitals and physicians, because once patients are stabilized, EMTALA no longer applies.[40] After stabilization, hospitals are free to refuse to provide further treatment or to transfer stabilized patients for purely financial reasons. On-call physicians can refuse to treat or admit stable patients or insist that stable patients be transferred owing to their lack of or type of insurance. An MCO can refuse further payment to the hospital and request that the stabilized patient be transferred to one of its contracting facilities.[41,42]

However, other federal, state, or local standards may govern further treatment or transfer of ED patients. For example, state laws often prohibit hospitals from transferring patients for any reason except that they are incapable of handling the patient's medical problem.

Two elements must be present to trigger EMTALA's stabilization requirement: (1) the patient must have an EMC, as defined by law, and (2) the hospital must determine that an EMC exists. That an EMC exists is not sufficient to invoke the duty to stabilize; the hospital also must have actual knowledge that the EMC is present. *Actual knowledge* is a legal term that means the examining physician subjectively believed that an EMC existed. It is not the commonly understood objective standard used in malpractice cases, wherein liability is predicated on whether the physician knew or reasonably should have known the patient had an emergency condition. Whether the physician's judgment was negligent, or even grossly negligent, is irrelevant under EMTALA. The *subjective perception* of the examining physician controls whether EMTALA's stabilization requirement is triggered.

The appellate courts have uniformly held that if an EMC is not detected, the hospital has no stabilization duty and cannot be charged with failure to stabilize the patient's condition.[9,43,44] Furthermore, consideration or suspicion that an EMC may exist does not rise to the level of actual knowledge. If the hospital fails to detect an EMC through its standard screening procedures, the patient has only a state malpractice claim of "failure to diagnose" and not a federal cause of action for "failure to stabilize" the emergency condition. Once the physician or hospital does diagnose an EMC, however, the courts will allow a failure-to-stabilize claim to be brought in federal or state court under EMTALA.

This aspect of EMTALA is distinctly different from ordinary malpractice. Documentation in the medical record of "no EMC present" eliminates all further liability under EMTALA;

physician

Emergency Medical Condition (EMC) Identified: (*Mark appropriate box(es), then go to Section II*) **[Dr. Bitterman - 2008]**

I. MEDICAL CONDITION: Diagnosis _____

☐ **No Emergency Medical Condition Identified:** This patient has been examined and an EMC has not been identified

☐ **Patient Stable -** The patient has been examined and any medical condition stabilized such that, within reasonable clinical confidence, no material deterioration of this patient's condition is likely to result from or occur during transfer.

☐ **Patient Unstable -** The patient has been examined, an EMC has been identified and patient is not stable, but the transfer is medically indicated and in the best interest of the patient.
I have examined this patient and based upon the reasonable risks and benefits described below and upon the information available to me, I certify that the medical benefits reasonably expected from the provision of appropriate medical treatment at another facility outweigh the increased risk to this patient's medical condition that may result from effecting this transfer.

II. REASON FOR TRANSFER: ☐ Medically Indicated ☐ Patient Requested _____

☐ On-call physician refused or failed to respond within a reasonable period of time.

Physician Name: _____ Address: _____

III. RISK AND BENEFIT FOR TRANSFER:

Medical Benefits:	**Medical Risks:**
_____ ☐ Obtain level of care/service NA at this facility. Service _____ ☐ Benefits outweigh Risks of Transfer	_____ ☐ Deterioration of condition in route _____ ☐ Worsening of condition or death if you stay here. There is always risk of traffic delay/accident resulting in condition deterioration.

IV. Mode/Support/Treatment During Transfer As Determined by Physician– (Complete Applicable Items):
Mode of transportation for transfer: ☐ BLS ☐ ALS ☐ Helicopter ☐ Neonatal Unit ☐ Private Car ☐ Other_____
Agency:_____ Name/Title accompany hospital employee: _____

Support/Treatment during transfer: ☐ Cardiac Monitor ☐ Oxygen – (Liters): _____ ☐ Pulse Oximeter ☐ IV Pump
☐ IV Fluid: _____ Rate: _____ ☐ Restraints – Type: _____ ☐ Other:_____ ☐ None

Radio on-line medical direction control *(If necessary):* ☐ Transfer Hospital ☐ Destination Hospital ☐ Other

V. Receiving Facility and Individual: ___ The receiving facility has the capability for the treatment of this patient (including adequate equipment and medical personnel) and has agreed to accept the transfer and provide appropriate medical treatment.

Receiving Facility: /Person accepting transfer: _____Time: _____

Receiving MD_____

Transferring Physician Signature_____ Date/Time_____

Per Dr. _____ by _____RN/Qualified Medical Personnel _____ Date/Time

nursing

VI. ACCOMPANYING DOCUMENTATION– sent via: ☐ Patient/Responsible Party ☐ Fax ☐ Transporter
☐ Copy of Pertinent Medical Record ☐ Lab/EKG/X-Ray ☐ Copy of Transfer Form ☐ Court Order
☐ Advanced Directive ☐ Other _____
Report given (Person/title):_____
Time of Transfer: _____Date: _____ Nurse Signature: _____Unit:_____
Vital Signs Just Prior to Transfer: T_____ Pulse _____ R _____ BP _____ Time: _____

patient

VII. PATIENT CONSENT TO "MEDICALLY INDICATED" OR "PATIENT REQUEST" TRANSFER:
☐ I hereby **CONSENT TO TRANSFER** to another facility. I understand that it is the opinion of the physician responsible for my care that the benefits of transfer outweigh the risks of transfer. I have been informed of the risks and benefits upon which this transfer is being made.
☐ I hereby **REQUEST TRANSFER** to _____. I understand and have considered the hospital's responsibilities, the risks and benefits of transfer, and the physician's recommendation. I make this request upon my own suggestion and not that of the hospital, physician, or anyone associated with the hospital.
The reason I request transfer is: _____

Signature of ☐ Patient ☐ Responsible Person_____ Relationship _____
Witness_____ Witness_____

TRANSFER FORM

White: Receiving facility; **Yellow:** Medical Record; **Pink:**-QA

Patient Name:
Date of Birth:
Medical Record Number:

Figure 202-1. Emergency Medical Treatment and Active Labor Act (EMTALA) hospital transfer form.

understanding and utilizing this distinction should be part of every ED's risk management program.

The screening section of EMTALA mandates the hospital to provide only those services within the capability of the *ED*, including ancillary services routinely available to that department.[5] The stabilization section, however, requires the level of services within the capabilities of staff and facilities available at the *hospital*.[45]

The capabilities of the hospital staff include whatever intensity of care the personnel of the hospital can provide within the training and scope of their professional licenses and hospital privileges.[27] To ensure that hospitals can stabilize patients, Congress mandated that Medicare-participating hospitals maintain a list of on-call physicians available to provide treatment necessary to stabilize a patient with an EMC.[46]

Thus, whenever the ED determines that a patient has an EMC, the hospital must utilize the full capabilities of its staff, facilities, and on-call physicians to stabilize the patient.[2,45] If the hospital is unable to stabilize the patient, a physician must certify that a transfer is medically indicated and arrange an "appropriate" transfer to a higher-level facility.

The treating physician should always decide whether a patient's EMC is stable or unstable. If two physicians disagree over whether the patient is stable but only one of the physicians is at the bedside caring for the patient, the on-site physician should make the decision.[2,9] It is *not* appropriate for an on-call physician, a "managed care gatekeeper" physician, a physician at a receiving facility, or even the patient's regular attending physician to disagree with the decision of the on-site physician over the phone. If one of these outside physicians wants to overrule the determination of the on-site physician, he or she must come to the hospital and personally examine the patient.

EMTALA defines the term *stabilized* as follows: "no material deterioration in the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility."[47] For a pregnant woman having contractions who has an EMC, stabilized means that delivery (including the placenta) has occurred.[48]

This is a *legal* definition of stabilization, not a medical definition. The standard of care for any patient diagnosed with an EMC will be judged by this legal definition, not by the usual medical malpractice standards. This is a national standard under federal law, not a local standard under state malpractice law.[9,48]

The "stabilized" question typically arises only when the patient deteriorates during or after the transfer and experiences an adverse medical result. It is likely to appear, particularly in hindsight, that the patient was not completely stabilized before transfer. Health care providers should remember that their compliance usually will be judged by an unsympathetic jury, aided by hindsight, in the context of impairments suffered by the patient in an adverse medical outcome. Unfortunately, the court system, not the health care system, will ultimately determine when a patient with an EMC is legally "stabilized."[9,48]

The U.S. Supreme Court, in the case of *Roberts v. Galen*, ruled that a plaintiff need not show improper motive for a transfer in order to prevail on a failure-to-stabilize claim under EMTALA. The plaintiff merely must prove that the patient was not properly stabilized before the transfer.[49]

It should be noted that all discharges from the ED are legally transfers under EMTALA, which exposes the hospital for claims under EMTALA for failure of its emergency physicians to stabilize patients with known emergency conditions before discharge ("transfer") home.[1,49]

EMTALA's requirement to provide on-call physicians no longer extends to inpatients diagnosed with an EMC.[2] Other Medicare conditions of participation govern inpatient care, and hospitals certainly should implement policies and procedures for providing emergency specialty services to patients in whom an EMC develops after admission to the inpatient setting.[2]

Disposition Issues under EMTALA

Admission

Admitting the patient to the hospital ends the hospital's duty under EMTALA, unless the admission is a ruse to avoid the hospital's EMTALA responsibilities.[2,44] As noted earlier, admission to "observation status" does not meet CMS's regulatory definition of "admitted," so EMTALA still applies to the care of observation patients in the inpatient setting, as well as those in an ED observation or chest pain unit.[2,24]

Once the emergency physician determines that the patient needs to be hospitalized, the patient's physician or the appropriate on-call physician should be contacted. If the admitting or on-call physician disagrees with the emergency physician's judgment, it is incumbent on the admitting or on-call physician to come to the ED to personally examine the patient. This fact should be mutually understood by the entire medical staff and the hospital administration and should be *written* into hospital policy and procedure.

"Discharge" or Transfer to Home

Under EMTALA, any patient movement away from the hospital is legally defined as a "transfer."[50] Thus, from a legal perspective, all patients discharged from an ED are considered to have been transferred. Sending a patient home after treatment in the ED who is retrospectively determined to be unstable is considered to represent a transfer of an unstable patient and, as such, a violation of EMTALA. To avoid such retrospective analyses, emergency physicians should document that no EMC was found or that the patient was stable on discharge. If the patient leaves without permission, the hospital has not legally transferred the patient.[50]

"Discharge" or Transfer from the Emergency Department to an On-Call Physician's Office

Because all discharges from the ED are defined as transfers under EMTALA, so too are discharges from the ED sent directly to an on-call physician's office for acute intervention. CMS looks askance at transferring patients away from the hospital to a physician's office for acute procedures that could have been done in the ED or in the hospital.[21,51] Ophthalmologist services may constitute an exception, because although the ED may have rudimentary eye tools, ophthalmologist typically have much better equipment in their offices for examining patients with eye complaints to determine whether an EMC is present or to treat emergency conditions. In essence, movement to the office in these cases becomes a medically indicated transfer to receive a higher level of services than the hospital can provide. CMS accepts such movement, so long as the ED arranges a formal transfer in compliance with EMTALA, as noted later on.

CMS's view is extremely unsatisfactory, particularly to orthopedic surgeons. It is standard practice in most hospitals for the emergency physician to splint various displaced fractures and send the patient to the on-call orthopedic surgeon's office for reduction of the fracture and further necessary treatment. CMS believes that the orthopedic surgeon should

perform the reduction and treatment at the hospital in each case, because the surgeon's office has no resources that the hospital lacks.

However, EMTALA applies only if the EMC is unstable at the time of transfer.[1,9] If the ED "stabilizes" the fracture, EMTALA's obligations end. Thus, it is reasonable to send patients to the office for further treatment, so long as they meet the legal definition of "stable at the time of discharge" from the ED. The determination of whether the patient is stable for transfer to the orthopedist's office rests solely on the judgment of the examining emergency physician. If the patient has accompanying injuries or is too uncomfortable to be moved, or if the emergency physician believes the injury is such that the patient should not travel, then the orthopedic surgeon should be asked to care for the patient in the ED.[9]

Follow-up Care

Obtaining follow-up care for discharged ED patients, particularly indigent persons and Medicaid recipients, is a significant problem for nearly every hospital. However, EMTALA does not reach the on-call physician's office in this scenario. If the patient does not have an EMC or is stable at the time of discharge, EMTALA does not apply from that point forward, and the on-call physician has no legal duty *under EMTALA* to see the patient in the office.

The real issue in ED follow-up is the level of commitment the hospital and medical staff are willing to make to the community. If the administration, the board, and the medical staff are comfortable with their decision, and if they have acted in the best interests of the patients they serve, they should have no trouble defending their actions to CMS or any other entity.

Whatever decision the hospital and physicians make regarding ED follow-up duties, they should explicitly define those responsibilities in the medical staff bylaws or hospital rules and regulations, so that all personnel understand, in advance, what it means to be "on call" for the ED at that hospital.

ED discharge instruction sheets also should include a *fail-safe clause* advising patients to return to the ED if their condition deteriorates before seeing the referral specialist or if the follow-up arrangements disintegrate for any reason. Such a statement could help the hospital avoid liability when the on-call specialist fails to implement the prescribed follow-up plan.[52]

Transfers to Other Acute Care Hospitals

Before transferring any patient out of the ED, the emergency physician must first determine whether the patient is stable, as defined by law. EMTALA regulates the transfer of unstable patients only; it does not apply to the transfer of stable patients.[2,9] If no EMC is found, the patient is considered stable. The determination of whether a patient is stable must be made at the time of transfer to be valid under the law.[51] Unstable patients can be transferred for only one of two reasons: if the transfer is medically indicated, or if the patient requests the transfer.[9] There is no "managed care transfer of an unstable patient" or even of a stable patient.

Patients usually are transferred out of the ED because the transferring facility lacks the capability or the resources necessary to treat the identified EMC. Examples of patients best served by transfer are the head-injured patient in a hospital without a neurosurgeon on staff, the pregnant woman who needs the services of a high-risk obstetric center, and the multiple-trauma patient treated initially in a rural ED who requires treatment at a level 1 trauma center.

EMTALA defines such transfers as "medically indicated transfers," because the purpose of each transfer is to obtain a higher level of medical care necessary to treat the patient's condition that is not available at the transferring facility. EMTALA governs almost every aspect of medically indicated transfers, including requiring hospitals to adopt and enforce policies to ensure compliance with federal transfer laws and mandating specific actions by the transferring and receiving hospitals (summarized in Boxes 202-1 to Box 202-3).[1-3,9,53-55]

BOX 202-1 Recommended Procedures for the Transferring Facility

1. Stabilize the patient whenever possible.
2. Complete a physician certificate of transfer, including the risks and benefits of transfer.
3. Obtain the patient's informed consent to the transfer.
4. Arrange for another hospital and physician to accept the patient in transfer.
5. Send appropriate data to the accepting facility (e.g., medical records, test results, transfer forms).
6. Arrange the transfer through qualified personnel, with use of appropriate transportation equipment.
7. Maintain records of all transfers for 5 years.

BOX 202-2 Invalid Reasons for Refusing an Appropriate Patient Transfer

- Lack of insurance or out-of-network managed care plan
- Lack of citizenship
- Veteran status
- Patient's physician not on staff
- Transferring hospital is out of network or outside hospital's defined referral area
- "We are not an affiliated hospital"
- "We are not a specialty hospital"
- "We are a specialty hospital, but that's not our specialty"
- "We are not a 'trauma center'
- Transfer originating out of county or out of state (including transfer of out-of-state Medicaid patients)
- EMS skipped over closer hospital
- Another hospital refused the transfer in violation of the law
- Another hospital's on-call physician refused to respond to its ED in violation of the law

ED, emergency department; EMS, emergency medical services.

BOX 202-3 Recommendations for the Facility Asked to Accept the Patient in Transfer

1. Accept all appropriate requests for transfer, regardless of whether the patient is an ED patient or an inpatient of the hospital.
2. Have a formal system for accepting or rejecting transfer requests, and document the reasons for any refusal to accept a patient in transfer.
3. Maintain records of all transfers for 5 years.
4. Report all EMTALA transfer violations to CMS.

CMS, Centers for Medicare and Medicaid Services; ED, emergency department; EMTALA, Emergency Medical Treatment and Active Labor Act.

Some states have enacted their own transfer laws.[56] Most state laws parallel EMTALA, but some are even more restrictive, so physicians responsible for patient transfers should be aware of the controlling laws and regulations in their own state as well as federal law.

Duty to Accept Appropriate Transfers from Other Hospitals

Medicare-participating hospitals that have specialized capabilities or facilities are required by EMTALA to accept appropriate transfers of patients who require such capabilities or facilities, if the hospital has the capacity to treat the patient.[57]

The duty to accept patients in transfer is a problematic issue for many larger, tertiary care, or academic hospitals as a result of the on-call specialty coverage crisis in the United States.[58,59] Numerous hospitals have lost full or partial on-call coverage for specialties such as neurosurgery, orthopedic surgery, maxillofacial surgery, neurology, plastic surgery, and hand surgery.[60,61] CMS's softening of its EMTALA on-call regulations in late 2003 accelerated the trend of physicians' simply taking fewer call nights at many smaller to medium-sized hospitals, forcing still more transfers to access emergency specialty care.[3,62,63] (As confirmed in recent surveys, these changes have accelerated physician and hospital abandonment of on-call services, increased the risk of harm to patients needing specialty care, caused more delay in patient access to specialty care, and increased the number of patient transfers.[62,63])

Specialty hospitals also enticed physicians away from acute care hospitals, in part because the physicians could decrease their on-call burden. However, CMS now requires specialty hospitals to accept appropriate transfers even if the specialty hospital lacks an ED.[64]

When Must a Receiving Hospital Accept a Patient in Transfer?

A Medicare-participating hospital must accept "medically indicated transfers" if it has "specialized capabilities or facilities" and the "capacity" to care for the patient.[1] *Medically indicated transfers* (see definition in the previous section on stabilization) are ones for which a physician determines the patient has an EMC and needs to be transferred to obtain a higher level of medical care necessary to treat the patient's condition that is not available at the transferring facility.[39] *Specialized capabilities or facilities* are essentially any resources, other than a routine admission bed, or physician services available at an accepting hospital but not available at the transferring hospital. *Capacity* is rather generously defined by CMS to include whatever a hospital customarily does to accommodate patients in excess of its occupancy limits. For example, if a hospital customarily moves patients to other units or calls in additional staff, then it has in fact demonstrated the ability to provide services to patients in excess of its occupancy limits.[65]

Who Accepts Patients on Behalf of the Hospital?

The duty to accept appropriate transfers is a hospital duty, not a physician duty, and EMTALA does not require that a physician accept the patient.[1] The hospital must create a formal system designating who is authorized to accept or reject patients on its behalf. It is strongly recommended that hospitals do not use the individual physician on call for each specialty *alone* to accept or reject patients in transfer. Hospitals should involve an administrative person or an emergency physician in addition to or instead of the on-call physician, to avoid inappropriate refusals. Because the duty to accept rests with the hospital, any inappropriate refusal by an uninformed or rogue on-call physician subjects the hospital to termination from Medicare, civil monetary penalties, or civil liability if the patient is harmed because of the refusal to accept the patient in transfer.

The hospital should define the resources and capacity of the institution, and the times during which those resources are available. When necessary resources or capacity are not available, the hospital must in a timely manner inform the persons charged with accepting or rejecting transfers. The hospital also should educate appropriate personnel in its known referral facilities on the proper procedure to transfer patients into its system, including informing them of who is and who is not authorized to accept patients in transfer on behalf of the hospital. The hospital must educate its medical staff, particularly its on-call physicians and emergency physicians, regarding their responsibilities under EMTALA, including the responsibility to accept patients in transfer from other facilities on behalf of the hospital.[66]

Does a Hospital Have to Accept Transfers of Inpatients from Other Hospitals?

CMS says no. In late 2008, CMS issued regulations stating that no hospital has a legal duty under EMTALA to accept an inpatient in transfer from another hospital. Therefore, even if a requested hospital could treat an inpatient's emergency condition that the transferring hospital is unable to treat, it may refuse the transfer for any reason and not be in violation of EMTALA.

However, the issue is certain to be litigated and decided by the courts. It is inevitable that an inpatient will develop an emergency medical condition and proceed to die or suffer severe damages because no other hospital would accept the patient in transfer due to lack of insurance. The patient or family will sue the hospital that refused to accept the patient in transfer, claiming that the hospital had a federal duty under EMTALA to accept appropriate transfers of patients with emergency conditions if the transferring hospital couldn't treat the emergency. The transfer acceptance section of EMTALA was not part of the law when it was originally enacted. Congress later amended the law, calling it the "non-discrimination" section, because tertiary and academic referral hospitals were refusing to accept patients in transfer from other hospitals, leaving the patients to die in community EDs.[67] It remains to be seen if the courts will ultimately interpret EMTALA contrary to Congress's "non-discrimination" intent for patients with life-threatening emergencies.[68]

When Can a Hospital Refuse to Accept a Patient in Transfer?

There are only five reasons a hospital can refuse a request for transfer under EMTALA.

First, if the transfer is not a "medically indicated transfer," a hospital can decline the transfer.[1] Non–medically indicated transfers include patient-requested transfers and lateral transfers for any reason (*lateral* meaning that both hospitals have the same ability to handle the patient's EMC), such as managed care transfers or family- or physician-requested transfers. Any time the sending facility can handle the patient's EMC, a hospital requested to accept the patient in transfer can lawfully decline.

Second, if the hospital does not have the "capacity," as defined by CMS, to accept the patient in transfer, it may and generally should refuse the transfer.[1,2,65]

Third, if the transferring hospital is located outside the boundaries of the United States, the hospital has no legal obligation under EMTALA to accept the transfer.[69] No other territorial limits are imposed on the duty to accept transfers; out of county, out of state, and out of the hospital's designated referral area all are unacceptable reasons to refuse patients in transfer under EMTALA. Moreover, a hospital cannot refuse to accept a transfer just because the sending hospital is "skipping over" other hospitals to send the patient its way.

Fourth, if the transfer is not "appropriate," the hospital may refuse to accept the patient in transfer at that time.[1] This more vague reason takes into account the patient's condition at the time of transfer and the time, distance, and "skipping over" other hospitals necessary to reach a receiving hospital. For example, a trauma patient may need intubation and a chest tube inserted before the transfer is "appropriate," or traveling 100 miles with hypotension from a ruptured abdominal aneurysm may not be "appropriate" if closer hospitals are capable of repairing the aneurysm.

Fifth, the patient has been "admitted" to the hospital as defined by CMS.

There are no other reasons for which a hospital may refuse a request to accept a patient in transfer from another acute care hospital under EMTALA. Furthermore, no "contingencies" are allowed to be placed on the acceptance of a transfer. The receiving hospital may not condition acceptance of the patient on the transferring hospital's agreeing to take the patient back once the emergency condition is resolved, may not require that the transferring hospital have additional consultations completed before the emergency physician transfers the patient, and may not require the transferring hospital to use the receiving hospital's transport ambulance or helicopter service as a condition for accepting the patient.[70]

Also, refusals of appropriate transfers on the basis of the patient's insurance status or delaying appropriate transfers until the transferring hospital obtains authorization for payment from the patient's managed care plan are definitely illegal under EMTALA.[71]

Duty to Report Transfer Violations

Any time a hospital has reason to believe it may have received a patient transferred in an unstable condition from another hospital, in violation of EMTALA, it must report the transferring hospital to CMS.[72] The duty to report rests with the hospital, so emergency physicians who receive unstable patients in transfer should inform the hospital, which then can determine the appropriate action.

CONSENT FOR MEDICAL CARE

Informed Consent

The doctrine of *informed consent* is a fundamental principle of the American legal system: "Every human of adult years with a sound mind has a right to determine what should be done with his own body."[73] Physicians may not examine or treat any person without consent, and that consent must be informed. This means that the patient must be given all pertinent ("material") information concerning the nature, risk, and alternatives of the treatment before that patient can be deemed to have effectively consented to the medical intervention.

Physicians should always endeavor to obtain informed consent yet remain cognizant of the significant limitations on and multiple exceptions to the doctrine, especially in the ED setting. Delaying treatment in an emergency to obtain informed consent is a much more serious and common medicolegal problem than failure to obtain proper informed consent.

The law of informed consent contains a great deal of uncertainty, with many gray areas. Different states have different views, either in their statutory laws (legislation) or in their common law (judge-made law or precedent), on the meaning of "informed consent" in the care of the ED patient. Most cases are unique and depend on the specific circumstances.

Emergency physicians rarely have time to seek legal consultations, let alone wait for a court to render a decision concerning the legal nuances of consent issues. In these situations, it is helpful for emergency physicians to use a "*when-in-doubt*" *rule* to guide their immediate actions. This rule simply states that when emergency physicians are in doubt regarding the legality of a situation, "they should do what they believe to be in the patient's best interest and worry about the legal consequences later." Although emergency physicians risk criminal and civil charges of false imprisonment, battery, and even negligence suits for failure to obtain appropriate informed consent, the courts almost universally rule in favor of physicians who act in good faith on behalf of their patients in emergency situations. Successful civil litigation regarding an issue of consent theory against an emergency physician acting reasonably, and consistent with the appropriate standard of care, is extremely rare.[74] An emergency physician is much more likely to be sued for failure to treat while waiting for consent than for providing reasonable treatment without consent.

Federal versus State Laws

Both federal laws (e.g., EMTALA) and state laws govern consent.[5,39] EMTALA comes into play primarily in the evaluation of minors and with patient refusal of an examination, stabilizing treatment, or transfer. State consent laws vary widely and may be set by statutes or case law, or both. The concepts discussed next are generally applicable to emergency medical care, but all emergency physicians should learn the consent laws specific to their own state.

The law presumes that an adult is mentally competent to make medical decisions and that the competent adult is entitled to sufficient information to make an informed decision concerning the physician's proposed course of examination and treatment.[74] Under the doctrine of informed consent, physicians have the duty to disclose the following information to patients[74-76]:

1. The patient's condition and/or diagnosis
2. The nature and purpose of the proposed treatment, including the likelihood of success in the physician's practice
3. Reasonable alternative measures related to the diagnosis and treatment, including the probable outcome of those alternatives
4. The particular known inherent risks that are material to make an informed decision about whether to accept or reject the proposed treatment, including the consequences of refusing that treatment

"Reasonable Person" versus "Professional Disclosure" Standard

The states are split on the standard used to determine what should be disclosed for patients to make informed decisions, but most require the "reasonable person standard" of disclosure. Under this standard, a physician must disclose all of the

information that a reasonable person would require to make a decision under the facts and circumstances of the case. The less frequent standard, termed "the professional disclosure standard," requires the physician to provide the same information that other physicians in the community would provide to patients in the same or similar circumstances. This is less stringent than the reasonable person standard.[74,76]

Physicians do not need to disclose every remote risk associated with a procedure, or risks that are common knowledge or obvious to the patient, such as the risk of infection after wound repair.[77] The law requires disclosure only of risks that are material, as judged by their seriousness or chance of occurrence. Courts define *material information* as information that "the physician knows or should know would be regarded as significant by a reasonable person in the patient's position when deciding to accept or reject the recommended medical procedure."[78]

Some states legally require physicians to disclose specific risks, such as death.[77] Some states statutorily require a physician to meet both the reasonable person standard and the professional disclosure standard.[79,80]

Physician's Role in the Consent Process

The physician who proposes to undertake the procedure must be the one to obtain the patient's informed consent. The duty to obtain consent cannot be delegated, so physicians cannot ask nurses or other health care providers to obtain patients' consent on their behalf. The physician who will care for the patient is best qualified to discuss the treatment and its risks and benefits with the patient. Nurses, as well as physicians not skilled in performing the procedure, cannot obtain valid informed consent.[81]

The physician should write or dictate into the patient's medical record a summary of the discussion held with the patient and family concerning the elements of informed consent. Particular attention should be made to documenting those material risks discussed with the patient before obtaining the patient's consent.

Consent is a *process*, not a signature. A written, signed, separate consent form is not legally required under the doctrine of informed consent; however, hospitals may require emergency physicians to complete standardized consent forms and obtain the patient's signature. The signed form is not a substitute for the consent process. It cannot replace the exchange of information that occurs between the physician and the patient and family, the answering of questions, and the ultimate agreement of the patient to undergo the medical or surgical intervention.[74]

A signed, written consent form, however, does constitute some evidence of a valid consent. In some states, a signed consent form is presumed to represent valid consent unless that presumption is rebutted by proof that the consent was obtained by fraud, deceit, or misrepresentation of material fact.[82]

Implied Consent in Emergency Situations

If an unconscious or incapacitated patient cannot express consent, the law will assume the patient consented to treatment for the emergency situation. Implied legal consent is premised on two principles: (1) duty to obtain informed consent is excused if death or irreparable harm may result if the physician delays providing treatment, and (2) the law presumes that a reasonable, competent, lucid adult would consent to lifesaving treatment.[83]

The emergency treatment allowed is limited to the circumstances of the emergency, however, and only treatment required to resolve the emergency should be undertaken without consent. Similarly, the emergency condition must require immediate medical attention, with insufficient time to inform the patient or seek consent from another person.

Courts differ on the definition of a "true emergency," and whether the emergency exception applies in a given case depends on the definition accepted by the court and the application of that definition to the particular set of facts. Fortunately, the courts generally will stretch the doctrine to protect physicians who act in good faith in caring for a patient with a perceived emergency condition.[84] This is one situation in which use of the "when-in-doubt rule" and documentation of the physician's concerns will weigh greatly in the court's determination of whether the physician acted appropriately without obtaining informed consent. Physicians can further protect themselves by obtaining a second opinion that a true emergency exists.

Minors

Minors Accompanied by a Parent or Legal Guardian

Parents and legal guardians have the right to consent on behalf of their minor children. However, they must act reasonably and in the best interests of their children. If they do not, their right to consent can be abrogated by the state or the courts. Parents are not allowed to refuse treatment for a child with a life-threatening emergency condition. The management of children with emergency conditions whose parents refuse to give their consent to treatment is discussed later.

Either natural parent of the minor child may provide legally binding consent. If one parent agrees with a proposed treatment and the other does not, consent may be accepted from the agreeing parent. Even if separated or divorced, either parent may give consent unless one parent has been judicially granted sole legal custody of the child, in which case only the custodial parent may consent. The child's biologic father, even if never married to the mother, also may consent for his child.

Unaccompanied Minors

EMTALA mandates that all persons presenting to an ED requesting care be examined to determine whether an emergency condition exists.[5] Because EMTALA is federal law, it takes precedence over all state consent laws regarding the initial evaluation of a minor child. In essence, the child's mere presence at an ED requesting examination or treatment constitutes legal consent to examine the child to determine whether an EMC is present. Furthermore, the hospital should *never* delay this initial screening evaluation in order to wait for consent from a parent or legal guardian (and nurse triage does *not* count as the required medical screening, no matter how nonurgent the child's condition appears to the nurse).

If an EMC is discovered through the initial screening examination,[5,39] the physician may treat the emergency under either state or federal legal theories. First, under state laws the standard emergency exception doctrine applies. State laws allow physicians to proceed with treatment whenever an emergency exists. Although no uniform legal definition of emergency exists among the states, state laws tend to define an emergency very liberally, such as "any threat to the minor's life or health." The courts almost always affirm a physician's judgment regard-

ing an emergency condition and rarely question the treatment given to a minor without parental consent.[85] Preserving life, preventing permanent disability, alleviating pain and suffering, and avoiding eventual harm have been used as guidelines for emergency treatment without consent.[85] Any minor presenting to the ED should be triaged and provided with an MSE to determine whether an EMC exists.

Under EMTALA, if an EMC is present, the hospital and physicians must provide "stabilizing treatment."[39] Federal law also gives the physician broad discretion to decide what treatment should be performed and in what time frame it should be accomplished. The stabilization requirement includes transfer as necessary to an institution capable of handling the minor's emergency condition. Thus, under federal law, a minor could be examined, stabilized, or transferred to another institution without consent ever being obtained from the family; in this instance, the care would be not only in the patient's best interest but also legally mandated.[5,39]

Generally, if the MSE does not reveal an emergency condition, physicians need to obtain proper consent from the minor's parents or legal guardian. However, state laws and the courts have applied a number of exceptions to allow minors to seek treatment on their own without parental consent. These exceptions vary widely from state to state, and most are applied through an analysis of facts and circumstances on a case-by-case basis by the courts. Under the *mature minor* exception, minors who possess an understanding and appreciation of the nature and consequences of the treatment and appear competent to make their own decisions are allowed to consent, despite not having reached the defined age for maturity (usually 18 years).[86] A mature minor usually is 15 to 17 years old.

The *emancipated minor* provides another exception to the need for parental consent. If the minor is living independently, is self-supporting, or is in the U.S. Armed Forces, the courts may recognize the minor as emancipated and able to consent on his or her own behalf. Again, this is determined by the courts on a case-by-case basis.[87] Additionally, most states have statutory reasons, such as sexually transmitted diseases, pregnancy, or domestic violence injuries, that allow minors to seek care without the consent of their parents.[88]

Incompetent or Incapacitated Adults

If a person has been declared legally incompetent by a court, consent must be obtained from the person's court-appointed legal guardian. In addition, people may appoint legal surrogates to make legal decisions for them should they become incompetent. State-sanctioned living wills, advance directives, and durable medical power of attorney documents all transfer consent powers from a person who becomes incompetent to a legally appointed surrogate.[89]

If an incompetent adult has neither a legal guardian nor an appointed surrogate, physicians typically look to the patient's family for consent to treatment. However, consent to treatment by a family member, even the patient's spouse, generally is not acceptable under American law unless the spouse or family member has been appointed legal guardian by a court of proper jurisdiction.[90] Marriage does not confer one spouse the legal capacity to consent to medical treatment for the other spouse, even when the ill or injured spouse is incompetent.

Some states recognized this problem and enacted "family consent statutes," which outline a hierarchy of family members who can legally provide consent when the family member becomes incapacitated.[91] However, even when families have no legal standing to consent for the incompetent relative, it is always wise to involve family in the medical decision-making process. Communication and concern for the family will avoid misunderstandings, surprise, and anger, which are the primary sources of litigation. Fortunately, if an emergency exists, no authorization from family is necessary to provide such reasonable care as is necessary to correct the life-threatening situation. Once the emergency is resolved, consent should be obtained from someone authorized to act on behalf of the incompetent patient. If there is no appointed legal guardian or surrogate and no state statute on family consent, the physician will need to seek consent authorization from the courts. The courts may appoint a guardian at that time, generally a family member, or after judicial review of the issues, the court itself may grant consent on behalf of the incapacitated person.

Other Special Patient Populations

Prisoners

Competent prisoners generally do not surrender the right to consent by virtue of being incarcerated. However, a state or court may compel treatment based on interests perceived as paramount to the prisoner's interests.[92] The elements usually necessary to treat self-inflicted injuries over the objection of the competent prisoner include the following[93]:

1. The injury to the prisoner was willful and intentionally self-inflicted.
2. The proposed treatment is necessary to preserve or restore the health of the prisoner.
3. The prisoner refuses to give consent.
4. The physician documents the medical indications for treatment in writing in the prisoner's medical record.

Alcohol-Intoxicated Patients

Alcohol intoxication itself may not render a patient incompetent to give informed consent.[94] The emergency physician must evaluate each situation individually to determine whether the patient is incapacitated by alcohol to the extent that he or she is no longer able to understand the proposed treatment, risks and benefits, and rational alternatives. In essence, the general rules for determining whether a patient is competent to make informed decisions cannot be disregarded just because the person is intoxicated with alcohol. However, the "when-in-doubt rule" is particularly applicable in these cases because alcohol intoxication often is associated with occult serious illness or injury.

Alcohol intoxication, particularly if documented by a measured blood alcohol concentration (BAC), is strongly suggestive to courts and juries of impaired mental status, even though health care workers recognize that many alcoholics are entirely rational and competent at fairly high BACs.[23,95,96] Conversely, low BACs do not guarantee competence, because other processes (e.g., hypoglycemia, blood loss, impairment from other illicit substances) may cause the patient to be incompetent. Thus, the patient's clinical capacity is more important than the specific level of alcohol in determining competence.

One advantage of obtaining a BAC is that some states allow blood samples drawn solely for medical purposes to be subpoenaed later by the prosecutor for use against the driver in a driving-while-intoxicated prosecution or other criminal charges.[23,97]

It is important to recognize that the state "legal limit" of intoxication is not a measure of a patient's competence. The legal level for driving has little, if anything, to do with the

capacity to make informed medical decisions. However, this distinction is sometimes difficult for judges and juries to understand, and the emergency physician can actually use the level to support a judgment that the patient was not competent to make informed decisions in a particular instance. At other times, it is better not to have a "number," so that the only relevant criterion for determining the patient's competence is the physician's judgment.[95]

Patients Given Pain Medications

Obtaining informed consent from patients treated with pain medications before a procedure is a common issue. As with alcohol intoxication, the mere fact that a patient has been given narcotic analgesia does not render that patient incapable of consenting to surgical procedures. Plaintiff attorneys can always argue "the patient was too snowed with drugs to give consent"; on the other hand, they can equally argue that the patient was "in too much pain to consent and would have agreed to anything to stop the pain." Accordingly, when consent is sought from a patient who has received pain medication, the patient's ability to understand the ramifications pertaining to the procedure should be assessed and taken into consideration, involving the family in the process if possible. The physician should document that the patient's premedicated state was considered when judging the patient's competence to make an informed decision.

REFUSAL OF MEDICAL CARE

Informed Refusal

The corollary to a patient's right to give informed consent is the patient's right to refuse medical care, even if such refusal results in death. In *Cruzan v. Director, Missouri Department of Health*, the U.S. Supreme Court determined that a competent adult has a constitutionally protected right to refuse medical care.[98] However, that right is not absolute. Under particular circumstances, courts will consider countervailing compelling state interests, such as preventing suicide, preserving life, and protecting innocent third parties.

Physicians who honor a competent patient's decision to refuse treatment are not liable for any resulting bad outcome.[99] In fact, physicians are more likely to be successfully sued for treating patients over their objections or without their consent, even when the treatment is lifesaving.

When a competent adult refuses indicated medical intervention, it often is because of fear, anger, misunderstanding, or some other failure in communication in the physician-patient relationship. Before allowing a patient to refuse care, the physician should try to determine and resolve the underlying reasons behind the patient's refusal.

The attending physician must always be involved when a patient refuses medical care or expresses the intent to leave against medical advice.[100,101]

As with consent, refusal of medical care is a process, not a signature. It must be an informed refusal; merely having the patient sign an "informed consent to refuse examination, treatment, or transfer" form or an "against medical advice" form is not sufficient. The four essential components of the process are discussed next.

Determining Competence

The physician must determine that the patient is competent to make decisions. Normal findings on the mental status examination without evidence of diminished mental capacity from closed head injury, severe pain, hypoxia, hypotension, alcohol intoxication, mental retardation, or mind-altering substances constitute good evidence of competency. Noting the patient's rationale for refusing care, even if it is not reasonable, provides additional evidence of competency.[102]

Ensuring an Informed Decision

To be legally binding, a decision to refuse a test or treatment or to sign out against medical advice must be an informed decision. The physician must explain the severity of the patient's condition, the potential complications, and the alternative treatments available. The physician should use terms that the patient can understand and provide the patient an opportunity to ask questions. The patient must understand that the risks of refusing care include the possibility of permanent disability and death. Ideally, a witness should be present when the physician informs the patient and any family members.[103]

Involving Others

The patient's family, friends, and personal physician should be involved whenever possible. These persons should hear the same message as that conveyed to the patient, because they may be able to persuade the patient to accept the recommended therapy. If the patient expressly forbids the emergency physician to speak with others, as is the patient's legal right, this should be explained to them and documented in the medical record.

Documenting Appropriately

Appropriate documentation of the refusal process is necessary to protect the physician and hospital from inappropriate litigation. The patient should be asked to sign the refusal form.[2,9,104] (Fig. 202-2 shows a sample AMA form.)

If the patient refuses to sign the form, that fact should be documented, and the form signed by a hospital representative who witnessed the patient's refusal. The medical record should reflect the patient's mental status examination findings and competency to make informed decisions, the risks and benefits of recommended treatments, the available alternatives, and the participating family or friends. Documenting the patient's rationale for refusing treatment, that the patient was treated to the extent allowed by the patient, and that the patient was invited to return for care at any time offers added protection.[104]

Federal Rules

EMTALA requires hospitals to take and document specific actions when patients refuse medical screening, treatment and stabilization, or transfer. The government and the federal courts presume that the patient requested emergency care and place the burden of proof on the hospital to demonstrate that the patient voluntarily refused care.[2,9,105]

There are essentially two scenarios in which patients leave the ED after refusing examination or treatment. First, some patients simply pick up and leave, without the knowledge of anyone affiliated with the hospital. If the patient's departure is witnessed, the patient does not respond to requests to return for the examination or to discuss the issues with the hospital staff. Hospitals generally refer to these patients as those who "leave without being seen" (LWBS) or "leave before examination." In the second scenario, the hospital personnel are aware that the patient is about to leave and have an opportunity to

INFORMED CONSENT TO REFUSE EXAMINATION, TREATMENT, OR TRANSFER

I understand that the hospital has offered: (Check all that apply).

A. ☐ To examine me (the patient) to determine whether I have an emergency medical condition, or

B. ☐ To provide medical treatment or to provide stabilizing treatment for my emergency condition, or

C. ☐ To provide a medically appropriate transfer to another medical facility.

The hospital and physician have informed me that the ***benefits*** that might reasonably be expected from the offered services are:

_____

_____

_____

and the ***risks*** of the offered services are: _____

_____

Physician Documentation

☐ The patient appears competent and capable of understanding risks and benefits.

☐ Alternative treatments discussed with the patient.

☐ Patient's family involved. ☐ Family not available. ☐ Patient does not want family involved.

Signature of Physician _____

Patient or Legally Responsible Person Documentation.

☐ I have declined to have the physician fully explain to me the risks, benefits, and alternatives to leaving the hospital against medical advice. I knowingly and willingly take and assume the responsibility for all risks incurred.
or
☐ The physician has fully explained to me the risks and benefits but I choose to refuse the offered services. I understand that my refusal is against medical advice, and that my refusal may result in a worsening of my condition and could pose a threat to my life, health, and medical safety. I understand that I am welcome to return at any time.

Signature/Patient or Legally Responsible Person _____

Print Name _____ Address _____

City _____ State/Zip _____ Date _____ Time _____

Witness/Signature _____ Print Name _____

The patient or person legally responsible for the patient was offered but refused to sign form after explanation of their rights and the risks and benefits of the services offered.

Hospital representative who witnessed refusal to sign: _____

Date _____ Time _____

Informed Consent to Refuse Examination Form [Hospital Addressograph or Sticker Goes Here]
White/Patient Record Yellow/Transfer with Patient Pink/Q/A [Robert A. Bitterman, MD JD - 2008]

Figure 202-2. Leaving against medical advice (AMA) form: Informed consent to refuse examination, treatment, or transfer.

interact before the patient leaves. Hospitals generally refer to this as "leaving against medical advice." The Office of the Inspector General (OIG) and CMS refer to both of these scenarios as "voluntary withdrawal" of the patient's request for evaluation or treatment.[2,9,106]

Leaving without Being Seen

If a patient walks out before the MSE and later has an adverse medical result, the burden will be on the hospital to prove that the person left voluntarily and was not denied examination or treatment by the hospital. The OIG and CMS admonish hospitals regarding LWBS patients, stating that "hospitals should be very concerned about patients leaving without being screened. Since every patient that presents seeking emergency services is entitled to a screening examination, a hospital could violate the patient antidumping statute if it routinely keeps patients waiting so long that they leave without being seen, particularly if the hospital does not attempt to determine and document why individual patients are leaving, and reiterate to them that the hospital is prepared to provide a medical screening if they stay."[9,25]

Hospitals need to have a policy and practice for LWBS patients that adequately document pertinent findings and protect the hospital from liability. In most hospitals, the staff calls the patient and checks the waiting area at least three times before declaring that the patient has left the department. These serial checks, with time of day performed, should be documented on the patient's record, and once it is evident that the patient is no longer present, the record should be reviewed on a timely basis by the physician on duty. If the reviewing physician discovers something of concern regarding the patient's chief complaint or triage data, the person can be contacted and encouraged to return to the ED. The registration papers, triage records, nursing documentation at triage, and the physician's review and documentation of that review all should be kept in the patient's permanent record. These records should be retained for a minimum of 5 years to protect the institution should the interaction ever be the subject of a retrospective EMTALA investigation or litigation on behalf of the LWBS patient.[2,9]

Leaving against Medical Advice

If hospital personnel are aware that a patient intends to leave before completion of the MSE or stabilizing treatment for whatever reason (e.g., tired of waiting, changes mind, concerned over cost of care), the hospital must handle and document the interaction carefully to avoid EMTALA or medicolegal liability.[2,9,107-109] (Box 202-4) In each case, the following steps should be taken:

1. *Inform the patient of the hospital's obligation under the law.* The ED staff should inform patients of their rights under the EMTALA to receive medical screening and any necessary stabilizing treatment from the hospital, regardless of their ability to pay for that service.
2. *Determine the patient's competence.* Only legally competent persons can refuse necessary medical care. For example, an alcohol-intoxicated woman who presents to the hospital with a medical complaint cannot be allowed to leave the hospital without examination and treatment until it is determined that she is legally competent to make such a decision.
3. *Explain the risks and the benefits to the patient.* For patients to make an informed consent to voluntarily withdraw their request for services, they must understand the benefits and the risks of withdrawal before refusing examination and treatment. These risks and benefits should be specific to the patient's chief complaint.
4. *Secure the patient's written informed consent to refuse care.* The hospital should take all reasonable steps to secure the patient's written and informed consent (i.e., obtain a signature) to refuse medical care. A standard form should be used that contains space for documenting the patient's competence, the risks and benefits discussed, and whether the patient's family was available to be involved in the discussions. If the patient refuses to sign the form and simply walks out after the interaction with the hospital, the person who discussed the issues with the patient and witnessed the patient's refusal should sign the form and document the interaction.
5. *Offer alternative care within the scope allowed by the patient.* It is outside professional practice standards to respond angrily, act vindictively, or punish patients when they decide to leave against advice by refusing to provide alternative treatments, medications, analgesics, or discharge instructions. Patients always get to define the scope of medical services they are willing to accept. Accordingly, an appropriate strategy is to negotiate and cajole them into allowing the best possible care under the circumstances that they define. For example, if a patient with "fight bite" tenosynovitis refuses hospital admission, operative intervention, and intravenous antibiotics and analgesia, then the next best option can be offered, such as thorough cleansing in the ED, intramuscular antibiotics, and oral narcotics, with recheck in 24 hours. Failing that, cleaning in the home sink, oral antibiotics, acetaminophen, and follow-up with the patient's primary care physician can be recommended.

   Negotiation aims for the best alternative that the patient is willing to accept, even if that means providing

BOX 202-4 Protocol for Managing AMA Cases in the Emergency Department (ED)

1. Always involve the emergency physician.
2. Involve the family and/or the patient's personal physician whenever possible.
3. Explain the risks and benefits specific to the patient's condition; "You could die" alone is too generic.
4. Explain any alternative treatment options to the patient.
5. Ascertain the patient's capacity to make informed medical decisions: "When in doubt, don't let 'em out!"
6. Have the patient and at least one witness sign the AMA form.
7. If the patient refuses to sign the AMA form, a member of the hospital staff should sign the form stating that the patient refused to sign the form.
8. Always still provide the best possible treatment within the scope allowed by the patient, including antibiotics and analgesics when warranted.
9. Provide appropriate discharge instructions, and welcome the patient to return to the ED at any time if he or she reconsiders and decides to accept the recommended care.
10. Document discussions with the patient, the risks explained, and the patient's medical decision-making capacity and understanding of the ramifications of leaving AMA in the medical record (and in real time—not hours after the patient has left the ED).

AMA, against medical advice; ED, emergency department.

less than optimal treatment. Also, pain medications should never be withheld because the patient will not accept the recommended treatment plan. This "strategy" is cruel, further alienates the patient, and serves no useful purpose.

Moreover, patients should *always* be invited to return to the ED (or encouraged to see their private physician) if they change their mind and become willing to accept the recommended treatment. A patient's refusal of the more appropriate treatments, as well as communication of offers to provide treatment within the circumstances proscribed by the patient, should be delineated.

6. *Document the interaction in the patient's hospital record.* The medical record, preferably a dictated and transcribed medical record, should accurately relate the interaction between the hospital and the individual refusing the MSE. The record reflects the hospital's conformity to the law and the patient's leaving of his or her own accord—specifically, the risks of refusing the examination and the reasons for the patient's refusal. Documenting the reasons for refusal provides evidence that the hospital did not economically coerce or in any way financially deter the patient from remaining for the MSE. The chart must clearly indicate that the patient did not leave the department based on a "suggestion" by the hospital concerning any financial issues.

Parent or Guardian Who Refuses Care or Blood Transfusions for a Minor

Generally, state laws support parental control of health issues affecting their children. However, the state will not allow parents to deny children needed emergency medical care under the doctrine of *parens patriae*, the state's paternalistic interest in children.[110] All states empower emergency physicians to intercede under their child abuse and child neglect laws.[111] When a child's injuries are potentially life-threatening, the emergency physician can take custody of the child under the child abuse laws and provide indicated treatment, including blood transfusions. In deciding whether to act, the "when-in-doubt rule" definitely applies, and all jurisdictions statutorily protect physicians from criminal and civil liability for acting in good faith to protect children.[111]

The courts have specifically addressed the issue of Jehovah's Witness parents attempting to refuse emergency blood transfusions for their minor children. All jurisdictions hold that a parent's right to freedom of religion does not include the right to deny life-sustaining medical intervention for that person's children.[112] One judge best summarized the feelings of the courts: "Not even a parent has unbridled discretion to exercise his or her religious beliefs when the state's interest in preserving the health of the children within its borders weighs in the balance."[113]

Some states specifically address the issue of overriding parental refusal of indicated medical intervention by statute.[114] In North Carolina, for example, if the parents refuse to consent to treatment, and the delay to obtain a court order would seriously worsen the child's physical condition or endanger the child's life, and if a second physician agrees that the procedure is necessary to prevent immediate harm, a physician can render treatment without parental consent. If a second physician cannot be contacted before initiating treatment, the physician may still perform the indicated therapeutic intervention without parental consent.[115]

Conversely, courts refuse to rule against the parents' wishes when the child's medical condition is not serious or life-threatening. If there is no life threat or potential for serious impairment, the parents' refusal should be respected. Parental refusal of indicated nonemergency medical treatment is usually statutorily defined as "child neglect," which is not legally sufficient to take custody of the child. Child neglect should still be reported to the appropriate authorities; treatment for the child can then be obtained under a court order.[111]

Jehovah's Witnesses

Adult Blood Transfusions

The approximately 1 million Jehovah's Witnesses in the United States believe that blood transfusion destroys their relationship with God and forfeits their chance for eternal life; accepting transfusion is not a minor infraction of their faith.[116,117] They do not accept whole blood, packed cells, platelets, white cells, or plasma or autotransfusion of stored blood. Most will allow the use of crystalloids, albumin, hemophiliac preparations, immunoglobulins, dialysis, and heart-lung machines.[116-118]

Jehovah's Witnesses and the issue of blood transfusion present difficult medicolegal issues in the ED.[119] State courts may have widely divergent views on the issue, and no clear-cut answers exist. However, the current trend is granting patients greater autonomy to refuse blood, even when the state asserts compelling interests to override a person's refusal.

General principles of consent and the "when-in-doubt rule" apply, but hospitals and medical staff also should (1) develop policies and procedures in advance to resolve potential conflicts with the Jehovah's Witness patients in the community; (2) coordinate the management of each case with hospital legal counsel, in contact with a judge who can issue court orders when appropriate, if time allows; (3) have other physician consultants write notes of agreement regarding the need to give blood; and (4) communicate effectively with patients and family, in advance when possible.

Competent Adult

The courts have found that "the competent adult has the right to refuse a transfusion regardless of whether his refusal to do so arises from fear of adverse reaction, religious belief, recalcitrance, or cost."[120] This applies "even though we may consider a patient's beliefs unwise, foolish, or ridiculous."[121] However, even this right is not absolute. If the patient's refusal conflicts with compelling state interests such as the preservation of life, the prevention of suicide, or the protection of innocent third parties, the courts may order transfusions despite the person's objections.[119] Previously, typical scenarios in which the courts overrode a competent person's refusal included cases involving pregnant women, to protect the life of the fetus; mothers of young children, to promote the general welfare of the children; and a sole supporting father or mother, to prevent offspring from becoming wards of the state.[122] Some courts, however, have significantly restricted the hospital's or state's ability to assert compelling interests challenging a competent person's right of self-determination.[123]

Unconscious or Medically Incompetent Adult

In an emergency, if the Jehovah's Witness's beliefs are unknown, physicians may transfuse the patient because consent will be implied under the emergency doctrine. It is irrelevant if the spouse, mother, or other family members adamantly refuse to allow the transfusion for religious reasons. The state's compelling interest in preserving life outweighs the family's expression of the patient's religious preferences.[118]

In the past, when a Jehovah's Witness's beliefs and transfusion preferences were known in advance, but the patient was

incompetent at the time of the emergency, the courts tended to support transfusion until the patient became competent and could refuse transfusion "contemporaneously."[112,124] The modern trend is to accept objective evidence of the patient's wishes—for example, a signed card carried by the patient that identifies him as a member of the Jehovah's Witnesses and sets out his religious objection to blood transfusion. The card may be accepted as adequate evidence of the patient's intent, like a form of advanced directive, which is binding on hospitals and physicians. In at least six states, if the card is dated and signed before two witnesses, it is statutorily valid.[125] Even if the blood refusal card does not conform to a state's advance directive statute, it should be considered strong evidence, but not necessarily determinative, of the Jehovah's Witness's wishes. Advance directives are merely a means to express an individual's rights and are not the exclusive means to express those rights legally.[118,119] Jehovah's Witnesses increasingly use state statutorily defined advance directive methods to legally express their intentions.[126] Emergency physicians should, however, be certain the card or advance directive actually belongs to the patient.

Of interest, no Jehovah's Witness has successfully sued a health care provider to recover damages in cases in which blood was withheld on the basis of an apparently valid blood refusal card. Also, "criminal, civil, or professional misconduct liability has never been imposed on health care providers for forgoing treatment the patient did not want."[127]

REPORTING REQUIREMENTS

All states require hospital EDs to report certain events or illnesses to local public health authorities.[128] The state's primary intent is to prevent the spread of communicable diseases, protect its citizens from disease and violence, and prosecute criminal acts. In each instance, the state statute overrides patients' rights of confidentiality. The statutes typically also provide physicians with immunity from civil liability or criminal prosecution if the reporting is done in good faith.[129]

All EDs should maintain up-to-date lists of diseases and incidents that must be reported to the state. The process and responsibility for appropriate reporting should be clearly articulated in departmental policy.

Communicable Diseases

Typical communicable diseases that must be reported include those of epidemiologic concern, such as sexually transmitted diseases (including gonorrhea, syphilis, chlamydial infection, nongonococcal urethritis, and human immunodeficiency virus infection) and highly communicable illnesses (such as tuberculosis, hepatitis, pertussis, and recently methacillin-resistant *Staphylococcus aureus* [MRSA] infection). Emergency physicians also have a duty to warn patients with communicable diseases against activities that may spread the disease and should instruct them to inform contacts to seek evaluation and treatment. Physicians should adequately document such instructions in the medical record to prevent liability to third parties for failure to warn appropriately.

Violent Acts

Wounds, injuries, and illness resulting from criminal acts of violence must be reported to state agencies.[130] Bullet wounds, powder burns, stab wounds, intentional poisonings, child abuse or neglect, sexual assaults, spousal abuse, domestic violence, and any suspicious injuries generally must be reported.

Deaths

All deaths must be reported to state or local authorities. Death under certain circumstances also must be reported to the county medical examiner. Typically these include (1) deaths from violence, poisoning, accident, suicide, or homicide; (2) any sudden death in someone in apparently good health or when unattended by a physician; (3) any death occurring in a jail, prison, or correctional institution or in police custody; and (4) any death occurring under suspicious, unusual, or unnatural circumstances.[131] Fetal deaths also may have to be reported, usually if over 20 weeks' gestation or the typical gestational period of possible viability.[132]

When a death requires a report to the medical examiner, the integrity of the scene and the body should be preserved. ED staff should disturb the body as little as possible, secure the patient's belongings and any potential evidentiary materials, and leave in place medical interventions such as endotracheal tubes, nasogastric tubes, and central or peripheral intravenous lines. The medical examiner will determine whether the state will assert authority over the body, order an autopsy, or release the body to the family.[131]

Additionally, any death that occurs while the patient is "restrained or in seclusion for behavior management," when it is reasonable to assume that the death is the result of the restraint or seclusion, must be reported to CMS.[133,134] In the ED setting, this typically would involve use of restraint or seclusion as a last resort to address violent behavior presenting a risk to the patient, hospital staff, or others.

Alcohol-Related Motor Vehicle Crashes

At least six states (Hawaii, Indiana, Illinois, Pennsylvania, Rhode Island, and Utah) have mandatory reporting laws governing alcohol-related motor vehicle crashes.[135] Many other states have laws permitting, but not requiring, EDs to report intoxicated drivers to authorities on the basis of a known BAC.[135,136]

Animal Bites

Most states require the reporting of animal bites, particularly dog and cat bites, to the local public health department. The states also generally require the reporting of bites by any animals known to be potential carriers of rabies, such as bats, raccoons, skunks, foxes, and cattle, to prevent cases of human rabies and control the spread of rabies within the animal community.[137]

Substance Abuse

A few states require reporting of substance abuse to local authorities.[138]

The references for this chapter can be found online by accessing the accompanying Expert Consult website.