

## Introduction

As a health-care provider, how often have you found yourself with a complex legal dilemma that requires a clear, concise response in the midst of a critical patient care event?

As a legal professional, how often have you been left to confront a complex medical decision-making process, when the legal direction may be clear?

As an administrator or management professional, how often have you had to balance the medical and legal aspects of a health-care situation that requires a nuanced outcome, focused on patient care?

This book is designed for medical providers, legal practitioners, and administrators both in practice and in training. The complexity of practice in emergency medicine requires a readily accessible source of complete and comprehensive information. This will allow medical practitioners first to prevent and then to address any legal risk that occurs. In addition, it will encourage legal professionals and medical administrators to participate in mitigation, prevention, and education programs.

The complexity of medical and legal dilemmas grows greater every day. Yet, no clear, concise, up-to-date book or data compilation is readily available to practitioners of all disciplines. Of course we have the internet, but a typical search has no filter to ensure that it delivers the highest-quality evidence or authoritative information.

My three decades of experience in emergency and critical care practice has made the need for a book such as this very clear to me. Its aim is to offer a clear pathway through some of the common, yet complex legal dilemmas encountered in day-to-day practice in emergency and acute care.

One important aspect of this book is the standardized presentation of problem, analysis, and problem-solving. First, the simple alphabetical listing of common medicolegal topics allows ease of

access. Second, the case study format of each chapter facilitates understanding of difficult health-care concepts. Third, the review of the relevant medical literature provides an analysis of evidence-based practice. Fourth, the legal literature review and caselaw analysis allows practical understanding of the medicolegal decision-making interface. Lastly, each chapter concludes with clear guidelines on how to deal with complicated health-care issues.

This book is meant to inform readers of the complex legal issues that are likely to be encountered in an emergency, critical care, and acute care practice. However, it is not meant to be a comprehensive analysis of the specific legal issues discussed, nor is it meant to be relied upon for legal decision-making. Certainly, actual situations will require the kind of individualized analysis offered by an attorney or counselor.

The subject areas discussed in this book are familiar in emergency medicine, but they are also topical. They include protective care issues such as abandonment, competence, confidentiality, domestic violence, geriatric protection, indigent care, pediatric care, pregnancy, and suicide prevention. Operational issues such as the admission process, bed boarding, frequent users, guidelines and protocols, overcrowding, telephone advice, and triage are also considered. Legal issues discussed include adverse event disclosure, civil commitment, duty to warn, emergency consent, malpractice claims, research consent, and subpoena. Public protection topics such as controlled substance use, driver impairment, and criminal acts are explored. Regulatory matters such as the Emergency Medical Treatment and Labor Act (EMTALA), Health Insurance Portability and Accountability Act (HIPAA), and Protected Health Information (PHI) are discussed in depth. Critical illness topics such as brain death certification, code response, resuscitation, and unanticipated death are reviewed. Lastly, problematic

## Introduction

management areas such as the disruptive provider, difficult patient encounters, professional boundary issues, and violence in the emergency department are examined.

To conclude, this work provides a unique and innovative examination of the complex interface of medical and legal principles in emergency, critical, and acute care medicine.

## Chapter

## 1

# Abandonment in the Emergency Department

## Case

The patient was an elderly woman, brought to the emergency department (ED) by emergency medical services (EMS) for difficulty walking. The paramedics said that she was unable to get around any more at home. When asked, they said the family was on their way and would follow the ambulance to the hospital. But no family members came. When the admitting physician asked the patient how she was, she said “I’m OK,” in a frail, delicate voice, with just a hint of a smile. She said she had difficulty walking, and her appetite had been poor over the last few weeks. When asked, she stated that she was cared for by a daughter and granddaughter who both worked hard jobs and had families of their own.

The history did not reveal any acute medical issues. She was quite aware of her circumstances, and she added that her primary care physician had discussed “putting her in a nursing home.” A physical exam found that she was weak, with poor muscle tone, but with no specific focus. The conventional laboratory and radiographic screening tests were all normal in relation to her age.

When ED staff eventually managed to contact the family, the local caregiver’s phone was disconnected and an out-of-state relative gave the ED another local phone number. The ED staff finally contacted a granddaughter, who tearfully stated she was at work at a new job and couldn’t come to the hospital.

## Medical Approach

An all-too-common scenario in the ED is a family member or family unit that can no longer effectively care for an elderly relative. Typically, there are financial or psychosocial stressors that cause the home care system to falter so that families feel they have no other choice but to turn to the hospital facility for help.

Often, our role in the ED is to help both patients and families.

Patient abandonment has been labeled “granny dumping” in the popular media.<sup>1</sup> The American Association of Retired Persons notes that patient abandonment is a small but growing problem in the health-care industry. According to the Centers for Disease Control (CDC), in the United States it tends to be more common in sunbelt retirement community areas such as Florida, California, Texas, and Arizona.<sup>2</sup>

The typical approach is that EMS are summoned for transport for a pretext illness and then a request for admission follows, or else there is no family response for a request to discharge the patient.

Most practitioners in this situation would turn to the Area Agency on Aging or the National Adult Protective Services Association for an objective analysis of the patient’s living circumstances. The Elder Justice Act, Title VI was included as part of the 2010 Patient Protection and Affordable Care Act.<sup>3</sup> This defined neglect as “the failure of a caregiver or fiduciary to provide the goods or services that are necessary to maintain the health or safety of an elder.” The behavior can be either active or passive, e.g., not providing access to nourishment, hydration, environmental protection, or economic self-determination.

Lachs et al. performed a nine-year observational cohort study of 2812 community-dwelling older adults linked with the elderly protective service records.<sup>4</sup> Protective services evaluated 6.5% (184) of the individuals, and found that one quarter, or 47 (1.6% of the total, 95% CI 1.0–2.1%) had corroborated abuse or neglect. A pooled logistic regression model found age, race, poverty, functional disability, and cognitive impairment to be associated risk factors. The study found the nature of social welfare screening overestimates the influence of race and poverty as risk factors.

## Legal Issues in Emergency Medicine

Remember, there is an obligatory requirement to report neglect of the elderly to authorities in all states, based on individual state statutes. The “mandated reporter,” often a medical professional who has an obligation to report, can be cited and subject to a fine of up \$1000 or 6 months incarceration, as well as incurring civil liability for not reporting in states such as California.<sup>5</sup> Penalties may be harsher if there is willful concealment or if this action results in a patient’s death.

### Legal Analysis

Abandonment issues are often centered around caring for people who are dependent, including those at age extremes both young and old.

#### For the Young

In *In re: Matter of Patricia Dubreuil*, the pregnant patient presented through the ED, signed a general consent, and required an emergency cesarean section.<sup>6</sup> However, she did not sign a blood transfusion consent form, as this would have violated her religious beliefs. As she was married but separated, the facility attempted to compel this lifesaving intervention, citing a theory of abandonment affecting her four children who were under her care. The district court held that in the absence of demonstrating the existence of a proper child care and custody plan, the state’s interest in prolonging her life outweighed her right to individual wishes regarding her medical care. The circuit court affirmed and she sought discretionary review, arguing her rights to privacy, bodily self-determination, and religious freedom had been infringed. The Supreme Court of Florida quashed the district court decision, finding that there was no evidence that her children would be abandoned.

In *Sacks v. Thomas Jefferson University Hospital*, a child was brought to the ED, requiring stitches on her forehead.<sup>7</sup> Her mother was permitted to remain during the procedure. The mother was asked to help hold the child but she felt faint, left the treatment room and fell, sustaining injury. The hospital moved for dismissal, alleging they owed no duty to the mother, who was not a patient. The district court affirmed this decision.

The Restatement (Second) of Torts (1965) provides: §323 Negligent Performance of Undertaking to Render Services. One who undertakes, gratuitously, or for consideration, to render services to another which

they should recognize as necessary for the protection of other person or things is subject to liability to the other for physical harm resulting from their failure to exercise reasonable care to perform his undertaking, if (a) their failure to exercise such care increases the risk of harm, or (b) the harm is suffered because of the other’s reliance upon that undertaking.<sup>8</sup>

Liability under §323 can only be imposed only upon “one who undertakes ... to render service to another” according to *Fabian v. Matzko*, 236 Pa. Super. 267, 270–271, 344 A.2d 569 (1975), as offered by the district court.<sup>9</sup> They held that the hospital cannot be held liable for causing the fainting episode or preventing the fall as no physician–patient relationship was ever established. They concluded the mother voluntarily entered the treatment area, was not required to help hold the patient, and “abandoned” her daughter when she felt faint and left the room. The defendant acquired no special duty to protect, or duty to direct family in an unpleasant medical circumstance.

#### For Older Patients

In *Carter v. Prime Healthcare Paradise Valley*, the elderly patient underwent hip surgery, presented to the ED with chest pain, and was transferred to a skilled care facility.<sup>10</sup> His condition gradually declined, with pneumonia and pressure ulcers, and he eventually died after a hospital visit. The family filed suit against the hospital and skilled care facility for violation of the Elder Abuse and Dependent Adult Civil Protection Act, alleging willful misconduct and wrongful death.<sup>11</sup> Here, abuse was defined as physical abuse, neglect, financial abuse, abandonment, isolation, abduction, or other treatment with resulting physical harm, pain, or mental suffering. The trial court sustained the defense demurrer without leave to amend as they held that the criteria required by the elder abuse statute such as abandonment were not met. The Court of Appeals of California, Fourth District, Division One affirmed the judgment, noting that alleged negligence is not the same as abandonment.

### Conclusion

The ED is often the center of controversy regarding neglect or abandonment of patients who may present in a poor health condition. The emergency medicine community has always attempted to err on the side of caution, relying on a strategy of hospital admission where uncertainty exists.

## References

1. Emergency rooms bearing the burden of abandoned elderly. *Deseret News*. November 29, 1991.
2. Arias E. United States life tables, 2009. *National Vital Statistics Reports* 2014;62(7):1–63.
3. Patient Protection and Affordable Care Act (Public Act 111–148), 42 U.S.C. & 18001 et seq. (2010).
4. Lachs MS, Williams CS, O'Brien S, Pillemer KA. Adult protective service use and nursing home placement. *Gerontol.* 2002;42(6):734–739.
5. California Welfare and Institutions Code §15630–15632.
6. *In re Matter of Dubreuil*, 629 So. 2d 819 (1993).
7. *Sacks v. Thomas Jefferson Hospital*, 684 F. Supp. 858 (1988).
8. Restatement of Torts Second §323 Negligent Performance of Undertaking to Render Services.
9. *Fabian v. Matzko*, 344 A.2d 569 (1975).
10. *Carter v. Prime Healthcare Paradise Valley*, 129 Cal. Rptr.3d 895 (2011).
11. Welfare and Institutions Code (WIC). Chapter 11. Elder Abuse and Dependent Adult Civil Protection Act [15600–15675].

## Chapter

## 2

## Abandonment of Patient by Treating Physician

### Case

The patient presented to the emergency department (ED) with chest pain. He was 55 years of age, but looked much older. He was slight in build, with hair thinning at the temples. He complained of substernal chest pain with radiation to the arm, and dyspnea on exertion. He improved with aspirin and nitroglycerin.

The ED physician attempted to admit him, but there seemed to be an issue. His attending physician stated that the patient could not be admitted to their service. They explained that the patient had recently been “fired from the practice” for ongoing non-compliance with treatment recommendations. When this issue was presented to the patient, he said that it was news to him. The patient stated that during an office visit last week his doctor had “got a little testy” with him. However, his current physician said the new doctor could have his records when they notified the new doctor’s office.

Once again, his primary care physician (PCP) was asked about the patient’s admission. “Just admit him to the on-call physician,” was the response. The PCP was asked if the patient had been properly notified of the ending of the relationship, and if a care transition plan had been put in place. The question was not answered, as he seemed perturbed, and replied “just notify the on-call physician to get him admitted.” The admitting physician for unassigned patients was contacted for the admission, but the case was referred to the medical staff office for an opinion as well.

### Medical Approach

There is a clear obligation to provide ongoing care when a physician–patient relationship is established. The patient is entitled to expect that care

will be provided until suitable arrangements can be made to transfer care to another health-care provider. Sometimes the care relationship can be terminated abruptly, leaving an ED physician to intervene.

Although a patient is free to leave a physician at any time, the physician has an obligation to provide a care transition plan. Abandonment may occur if an existing patient–physician relationship is unilaterally terminated by the health-care provider when the patient has ongoing health-care needs and there is no adequate care transition plan (Table 2.1).

Five elements are required to support a cause of action for the tort of health-care abandonment.<sup>1</sup> First, the health-care treatment was unreasonably discontinued. Second, the termination of the health-care relationship occurred without the patient’s knowledge. Third, the health-care provider failed to enact an acceptable care transition plan. Fourth, the provider should have reasonably foreseen the hazards arising from this premature termination; this firmly establishes the proximate cause relationship. Fifth, the patient suffered harm as a direct result of this termination (Table 2.2).

The Healthcare District of Palm Beach County has promulgated the following five-step program to avoid patient abandonment accusations.<sup>2</sup> First, they suggest providing written notice by certified mail with return receipt. Second, the health-care professional should provide a succinct explanation for the change, such as therapeutic non-compliance or appointment cancellation. Third, a transition timeframe of 30 days of ongoing care appears to be the standard. Fourth, the provider should help to recommend or facilitate the transfer to another provider. Fifth, the patient should be asked for a signed consent to facilitate the medical record transfer to another health-care professional (Table 2.3).



### Abandonment of Patient by Treating Physician

**Table 2.1** Patient–physician abandonment criteria

1. Pre-existing relationship
2. Unilateral termination by physician
3. Ongoing health-care need
4. No transition plan provided

**Table 2.2** Five elements of abandonment cause of action

1. Treatment unreasonably discontinued
2. Termination of health care without the patient's knowledge
3. Failure to arrange for follow-up care
4. Reasonably foreseeable consequences of termination
5. Patient suffered harm or loss

Reference: Indest.<sup>1</sup>

**Table 2.3** Five-step program to avoid an abandonment allegation

1. Provide written notice by certified mail
2. Provide brief explanation
3. Provide service for a 30 day transition period
4. Provide a referral recommendation
5. Facilitate record transfer with signed consent

Reference: Wiewora.<sup>2</sup>

## Legal Analysis

In *Mack v. Soung*, the patient was placed in a nursing facility during her final days. She developed a decubitus ulcer that was treated on site, after which her physician allegedly refused to transfer her to the hospital.<sup>3</sup> She died a few days after the physician gave written notice of his withdrawal from her care, mailed to the patient's former residence, but did not contact her family directly. The family alleged "willful and abrupt abandonment," and brought suit alleging multiple legal theories and submissions. They cited the Elder Abuse and Dependent Adult Civil Protection Act §15600 et seq., which states that:

Any person who has assumed full or intermittent responsibility for the care or custody of an elder or dependent adult, whether or not that person receives compensation, including ... any elder or dependent adult care custodian, health practitioner ... is a mandated reporter;

and a complaint of intentional infliction of emotional distress.<sup>4</sup> The trial court sustained demurrers to both causes of action without leave to amend. The appellate court affirmed in part, holding that this behavior did not fulfill the criteria for intentional infliction, and reversed the decision in that health-care professionals who assume care are liable for neglect, abuse, or abandonment.

In *Elder v. Sutter Medical Foundation*, an unpublished opinion refers to a lawsuit filed concerning the care continuum from the facility to the convalescent care center and managed care provider.<sup>5</sup> The patient fell, injuring her lower leg, progressed from the hospital to the convalescent care center, and was discharged home. There was allegedly an issue with authorization for an outpatient anticoagulant for management of a thromboembolism to which she eventually succumbed. The patient's family filed suit alleging elderly abuse, wrongful death, and abandonment, citing failures of continuing duty of care relating to the referral, communication, and medication certification. The trial court sustained the demurrers of the care center and foundation and entered judgment in their favor, holding there was no evidence of abandonment. Abandonment was defined as "the unilateral severance by the physician of the professional relationship with the patient without reasonable notice at a time when there is still the necessity of continuing attention."<sup>6</sup> The appellate court affirmed the decision that the essentials of abandonment were not pled successfully by the plaintiff. However, the state department of health found violation of a state regulation requiring established procedures to handle medical emergencies with deviation from admission criteria and process policy. "Home health providers are required to have in place written policies and procedures that include a plan to handle medical emergencies."<sup>7</sup>

## Conclusion

There are clear, well-established guidelines regarding the unilateral severing of the patient–physician relationship that must be followed in order to avoid ethical and legal violations. Obviously, this provision is only available in the context of non-emergent patient care.

## References

1. Indest GF. Patient Abandonment. *Home Health Care Law Manual* (Gaithersburg, MD: Aspen Publishers, 1996).

### Legal Issues in Emergency Medicine

2. Wiewora RJ. Ending the patient/physician relationship. Access 2012;143:2.
3. *Mack v. Soung*, 95 Cal. Rptr.2d 830 (2000).
4. Welfare and Institutions Code (WIC). Chapter 11. Elder Abuse and Dependent Adult Civil Protection Act [15600–15675].
5. *Elder v. Sutter Medical Foundation*, No. C077380, January 12, 2016.
6. *James v. Board of Dental Examiners*, 172 Cal. App.3d 1096 (1985).
7. California Code of Regulations 22 CA ADC §74721: Written Administrative Policies, subd (c) (1).



## Chapter

## 3

## Admission

### Case

The patient had presented with a “blister” on the bottom of her foot. That was her only complaint, and she had no fever or other systemic illness. Her hygiene was poor and her appearance gave rise to concerns about her living circumstances. Her medical history did not reveal diabetes or vascular insufficiency. She declined an offer of social service evaluation to potentially assist.

On completion of the physical exam, it was noted there was no redness or drainage at the site: just a single, apparently chronic, dense callus located at the base of her first metatarsal. The physician attempted to reassure her that everything was fine, and the callus could be followed on an outpatient basis by the podiatry service. The patient voiced her disapproval of this plan. Another attempt at reassurance failed, so she was offered some additional testing. The complete blood count, basic metabolic panel (BMP), C-reactive protein, and plain radiograph of the foot were normal. These results were discussed with the patient, without achieving better insight, but in other respects her decision-making was normal.

She then stated that she “knew her rights,” and that the medical staff were obligated to admit her to the hospital according to the “Hill–Burton Act.” Further consultation with mental health found she was indeed competent. The patient advocate concurred with the discharge plan, but felt that the offer of services was required and courtesies should be extended. A follow-up appointment was made and transportation home was offered, which the patient accepted.

### Medical Approach

It is important to recognize that hospitals are not required to admit patients. This assumes a reasonable medical evaluation, performed by the person qualified

to do so at that institution. If this person concludes that the patient is not experiencing an acute medical condition, the patient can be directed to care delivered in the outpatient setting, as was done in this case.

Since 2010, the Patient Protection and Affordable Care Act (ACA) has invoked the “prudent layperson, acting reasonably” standard for determining a medical emergency that would compel payment by the insurer.<sup>1</sup> For Medicare hospitals the Centers for Medicare & Medicaid Services (CMS) requires that inpatient admissions be supported by the clinical documentation and supplemented by a specific diagnosis and treatment plan.<sup>2</sup> They recommend that screening tools should be used, not exclusively, but as part of the overall evaluation process. In addition, they state that inpatient care be “necessary, reasonable and appropriate” for that specific patient, in that particular set of circumstances.

The Hospital Survey and Construction Act (Hill–Burton Act) was enacted in 1946/7 awarding grants and loans to hospitals for postwar construction and modernization.<sup>3</sup> The community service obligation mandates that the facility should provide emergency service to people within its catchment area as long as they operate with a not-for-profit (NFP) status. The uncompensated care provision provides free or reduced-cost care for 20 years after project completion, and is means tested and time limited. According to the Department of Health and Human Services, in 2015 only 152 hospital facilities nationwide had a remaining free or reduced-cost health-care obligation.<sup>4</sup> Clearly, a significant amount of uncompensated or reduced-fee care is provided by most facilities, but only a minority is related to this particular law.

### Legal Analysis

In *Richard v. Adair Hospital Foundation*, the family alleged their child was denied admission to the

### Legal Issues in Emergency Medicine

emergency department (ED) on two occasions.<sup>5</sup> The limited proof in the record comes from the family depositions. They allege they drove their sick child to the door of the ED. Mother and baby remained in the vehicle, where the appellant claimed the nurse refused to examine the child or call the doctor. The family left, and could not find their own doctor. They returned to the ED 2 hours later with the same request, and were met in the driveway by the nurse, who allegedly stated the child did not have a fever. The child was transported to another facility about 9 hours later, was admitted with pneumonia described as critical, and died.

A physician testified that the child's survival chances would have been greater if admitted at the earlier visit. The trial court awarded the defense's summary judgment motion as there was no genuine issue in fact as causation could not be established. The Court of Appeals of Kentucky reversed the decision, holding that the hospital twice refusing admission, when an unmistakable emergency situation may have existed, was an issue of fact and the summary judgment for the defense was premature.

In *Hunt v. Palm Springs General Hospital*, the patient presented with seizure after taking his chronic medications, was seen by an "unlicensed resident physician," who then contacted his physician, and was subsequently discharged home.<sup>6</sup> He returned to the ED about 10 hours later and was seen by his physician. An admission inquiry found there were previous unpaid bills. This admission decision could have been overridden by the attending physician if an emergency condition existed, but it allegedly was not. The patient was then moved from the ED room to the adjacent hall, and transferred to another hospital 4 hours later, where he died the next day. The trial court awarded a

directed verdict to the facility holding there was no duty, as he was seen by his physician and not admitted. The District Court of Appeal of Florida, Third District reversed and remanded for a new trial, holding that the duty to a non-admitted patient was a question for the jury. As well, they erred in a hypothetical distinction between the resident, attending physician, and hospital in assigning responsibility.

### Conclusion

The obligation to evaluate and treat patients has a legal basis in common law, case precedent, and statutory regulation. Most physicians have the capability of entering into a care contract with mutual consent to exercise their skill in caring for the patient. The duty to treat is self-evident in emergency medicine, with all patients encountered at least being screened for additional care needs.

### References

1. Patient Protection and Affordable Care Act (Public Act 111-148), 42 U.S.C. & 18001 et seq. (2010).
2. Medicare Program Integrity Manual, Chapter 6, Section 6.5.1, [www.cms.gov/manuals/downloads/pim83c06.pdf](http://www.cms.gov/manuals/downloads/pim83c06.pdf).
3. Hospital Survey and Construction Act of 1946 (Hill-Burton Act), Title VI of Public Health Services Act. 42 C.F.R. §53.111-113.
4. Health Resources and Services Administration (HRSA), Department of Health and Human Services, Hill-Burton Free and Reduced-Cost Health Care, [www.hhs.gov](http://www.hhs.gov).
5. *Richard v. Adair Hospital Foundation Corporation*, 566 S.W.2d 791 (1978).
6. *Hunt v. Palm Springs General Hospital*, 352 So. 2d 582 (1977).