AMERICAN COLLEGE OF EMERGENCY PHYSICIANS
SCIENTIFIC ASSEMBLY
1999

EMS and the Law

Most emergency physicians are responsible for some online control of emergency medicine by radio or telephone. Many emergency physicians are not fully aware of the risks, liability, and responsibility that this entails. The risks and obligations of the emergency physician in online medical control will be described, with case studies used to demonstrate important considerations. Expert faculty will also explore the impact of EMTALA legislation and its potential consequences. Patient consent, competence, and refusal will also be discussed. (Participants can submit cases in advance for consideration.)

- Recognize the risks and obligations of the emergency physician when providing online medical control.
- Discuss how to deal with the issues of consent and patient refusal.
- Discuss the latest COBRA/EMTALA regulations and their impact on prehospital care.

MO-27
Monday, October 11, 1999
12:30 PM - 2:25 PM
Room # N242
Las Vegas Convention Center

FACULTY

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EMS and the Law

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American College of Emergency Physicians
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Part One: General EMS Issues On Line

Control of Emergency Medicine

- Risks of the emergency physician.
- Obligations of the emergency physician:
  - Importance of protocols; and
  - Importance of good quality assurance program.

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Managed Care Issues

- Work with managed care plans (examples):
  - Utilization management decisions - e.g. whether to send a paramedic ambulance or a basic life support vehicle;
  - Call center responsibilities; or
  - On-scene triage for medical necessity.

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Managed Care Issues (cont.)

- Recommendations for dealing with managed care issues:
  1) Make sure the proper personnel are making decisions consistent with their scope of practice (*e.g.*, physicians, nurses, and physician assistants);
  2) Make physician back-up is available - especially before a decision is made to deny care;

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Managed Care Issues (cont.)

- Recommendations in dealing with managed care issues:
  3) Make sure that protocols used are validated and peer reviewed;
  4) Make sure that there is an effective quality assurance program that evaluates such decisions;
  5) Make sure that contracts with managed care companies are reviewed carefully with legal counsel; and

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Managed Care Issues (cont.)

- Recommendations in dealing with managed care issues:
  6) *Watch out for telephone triage!*
     - Can create a special duty exception to the "public duty doctrine," which states that the duty of a public safety communication center is to the public at large and not to an individual caller.
     - Can create a problem with governmental immunity that applies to municipality and its employees when they are performing a discretionary public function.

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Patient Competence, Consent and Refusal

- "Capacity"
  - Legal: presumed.
    - Exceptions: Minors.
    - Exceptions: Prisoners and people who have been arrested.
- Medical decision-making capacity:
  - Governed by state law.
  - Generally also presumed unless:
    - Conserved and having lost medical decision-making capacity; or
    - Unable to communicate - (*e.g.*, coma); or
    - Physician finding that patient lacks capacity.

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Advance Directives

- Advance Directives
  - General principles:
    - No effect unless patient lacks decision-making capacity or defers decision to an agent.
    - Patient need not be terminal in order for wishes to be followed.
- Again, may be governed by state law
  - Examples

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Advance Directives (cont.)

- Several types of advance directives
  - Best - durable power of attorney for health care
    - Names agent; and
    - Can express specific binding wishes.
- Living will - generally states what the patient does not want to have done.

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Advance Directives (cont.)

- Do not resuscitate orders:
  - Also may be a creature of state law; and
  - May or may not be considered "advance directives."
- How to deal with conflicts:
  - Between written documents; or
  - Between written documents and relatives
- Value of education about advance directives and EMS

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Part Two:
EMTALA: Don't Let the COBRA Bite!

Medical Screening Examination

- A medical screening examination is required for all those who present "to the emergency room" for examination and treatment of an emergency medical condition.

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Medical Screening Examination (cont.)

1) The hospital must provide an examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department.

2) Purpose: to determine whether an "emergency medical condition" exists.

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Medical Screening Examination (cont.)

3) Distinction from "triage."
   - Triage within 15 minutes of arrival; and
   - Recheck every 45-60 minutes for urgent and every 2 hours for non-urgent patients.

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Hospital Property

4) For purposes of this section, "property" means the entire main hospital campus, including the parking lot, sidewalk, and driveway, as well as any facility or organization that is located off the main hospital campus but has been determined to be a department of the hospital.

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Hospital Property (cont.)

5) It is required, regardless of where the patient presents on hospital premises, including hospital-owned ambulance or other ambulance that disregards diversion instructions.

6) Ravenswood Hospital.

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New HCFA Interpretive Guidelines

- "Appropriate medical screening examination": The process required to reach, with reasonable clinical confidence, the point at which it can be determined whether a medical emergency does or does not exist.
- The medical screening examination is not an isolated event. The record must reflect continued monitoring.

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New HCFA Interpretive Guidelines (cont.)

- Lack of an established emergency department is not an indication that emergency services are not provided. The emergency department must have a mechanism for providing physician coverage at all times.
- If a hospital offers a service to the public, the service should be available through on-call coverage.

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New HCFA Interpretive Guidelines (cont.)

- The physician at the sending hospital (and not the receiving hospital) has the responsibility to determine appropriate mode, equipment, and attendants for transfer.
- "Stable for transfer" and "stable for discharge" do not require final resolution of the emergency medical condition.
- A psychiatric patient is considered stable for discharge when he is no longer considered to be a threat to himself or others [what does this mean?].

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New HCFA Interpretive Guidelines (cont.)

- A patient may be sent to a hospital-owned facility which is:
  - Contiguous to ER or part of the hospital "campus;"
  - Owned by the hospital; or
  - Is operated under the hospital's Medicare provider number.
  - This *only* applies if all patients with same or similar medical conditions are moved to this location, regardless of their ability to pay; there is a bona fide medical reason to move the patient; and qualified medical personnel (QMP) accompany the patient.

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Proposed OIG Advisory Bulletin on Managed Care

- Says a hospital should not ask a patient to complete a "financial responsibility form or an advance beneficiary notification form."
- States that hospitals should hire financial counselors.
- Warns that Medicare and Medicaid managed care plans that fail to provide medically necessary services, including emergency services, are subject to sanctions.

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Proposed OIG Advisory Bulletin on Managed Care (cont.)

- States that plans may not require prior authorization for emergency services.
- Requires plans to pay for emergency services without regard to whether they have a contractual relationship with the hospital.

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Proposed OIG Advisory Bulletin on Managed Care (cont.)

- Requires plans to pay for emergency services based on a "prudent layperson" standard.
- Discusses the potential problems associated with having "dual staffing" or a separate evaluation and treatment track for managed care patients.

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Roberts v. Galen of Virginia

- First U.S. Supreme Court decision that construed EMTALA.
- Court did not reach issue of how long EMTALA applies after initial emergency.
- Holding: No requirement to prove improper motive for EMTALA case alleging violation related to transfer or stabilization.

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Roberts v. Galen of Virginia (cont.)

- Open Questions
  - Do EMTALA's stabilization and transfer requirements apply to patients who are not in the Emergency Room?
  - Do admission of a patient and provision of treatment terminate EMTALA obligations concerning stabilization and transfer?

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Roberts v. Galen of Virginia (cont.)

- Highlights from Oral Argument
  - Assistant to the Solicitor General informed the court that the Secretary of HHS intends to institute new rule-making to address:
    - How far a hospital's obligation extends; and
    - How long it extends under EMTALA.
  - Currently, the Secretary takes no position on how long the obligation lasts.

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Definition of "Emergency Medical Conditions"

- Acute symptoms of sufficient severity.
- Includes symptoms of severe pain, psychiatric disturbances and substance abuse.
- The absence of immediate medical attention could reasonably be expected to result in jeopardy to health, serious impairment or serious dysfunction of any bodily organ or part or inadequate time to transfer pregnant woman is having contractions.

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Transfer

- If a person has an emergency medical condition, the hospital must restrict transfer of a patient until he or she is stabilized unless:
  - patient refuses to consent to treatment or transfer (document!); or
- The benefits of transfer outweigh the risks of transfer. Requires either:
  - physician certification *or*
  - certification by a "qualified medical person" (approved by the hospital board) subsequently countersigned by a physician.

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Definition of "Stabilize"

- No material deterioration likely within reasonable medical probability.
- In a woman who is having contractions and who cannot be safely transferred, that the woman has delivered the child and the placenta.

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Definition of "Appropriate Transfer"

- The transferring hospital provides treatment within its capability;
- The receiving facility has available space, personnel and equipment, and has agreed to accept the patient [may include a receiving physician];
- the transferring hospital sends appropriate medical records; *and*
- the transfer occurs through qualified personnel and transportation equipment.

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"Specialized capabilities or facilities"

- May not refuse appropriate transfer.
- Examples (non-inclusive list): burn unit, shock trauma unit, neonatal intensive care unit.
- May include *any* service the receiving hospital has that the transferring hospital does not have (general surgery?).

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Log (Central)

- Date;
- Time;
- Name;
- Chief complaint;
- Final diagnosis;
- Disposition:
  - Admit;
  - Discharge;
  - Transfer; or
  - AMA, left without being seen or elopement.

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Sanctions

- Medicare or Medi-Cal decertification: usually "fast-track."
- Civil monetary penalties:
  - Office of Inspector General ($50,000/violation or $25,000/violation for hospitals with less than 100 beds).

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Sanctions (cont.)

- Whistleblower protection
- Patient lawsuit
- Failure of receiving facility to report receipt of inappropriate transfer:
  - Possible decertification
  - May even be "fast-track"
- IRS: possible loss of tax-exempt status

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Physician issues

EMTALA specifies that any physician who is responsible for examination, treatment, or transfer of a patient, and who knowingly violates the requirements is subject to civil monetary penalties and/or exclusion from the Medicare program. On-call physicians can be held responsible if the transfer of an unstable patient is due to their absence.

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Physician issues (cont.)

EMTALA requires the transferring hospital to forward the name and address of the on-call physician whose failure or refusal to appear within a reasonable period of time to provide necessary stabilizing services is the cause of a transfer. An emergency room physician who transfers patient under these circumstances is immune. The transferring hospital and the on-call physician who failed or refused to respond will remain potentially liable.

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