Medical Legal

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MEDICAL LEGAL
ASPECTS OF EMERGENCY MEDICINE

I. MEDICAL MALPRACTICE

A. Malpractice litigation is based on a negligence theory

B. Four elements of negligence:
   1. Duty
   2. Breach of duty
   3. Causation
   4. Damages

C. Duty

   1. The patient must prove that the physician owed the patient a particular duty or obligation.
   2. Physician’s duty to patient is created by the physician-patient relationship.
   3. Physician-patient relationship may be created under several circumstances:
      a. Emergency department – duty created when patient comes to Emergency department and requests to be seen by physician
      b. Telephone advice – may have duty to patient if incorrect advice given over telephone
      c. On-call physicians
      d. Duty to warn non-patients of specific danger [Tarasoff v Regents of University of California, 551 P.2d 334 (1976) – California Supreme Court]

D. Breach of duty

   1. The patient must prove that the physician failed to act in accordance with the “standard of care”
   2. Standard of care
      a. Definition: Exercising the skill, care and knowledge that a reasonably well-qualified practitioner in the same specialty would apply under the same or similar circumstances. Some courts also apply locality rules
      b. Expert witness is needed to help judge and jury
         i. Understand topics, facts, terminology beyond comprehension of average juror
         ii. Expert witnesses define the “standard of care”
         iii. Generally the ONLY time witnesses can offer opinion testimony
         iv. Bad outcomes not equivalent to breach of standard of care, but many experts will testify to this effect
c. Exceptions to need for expert testimony:
   i. Physician’s own testimony — *DEPOSITIONS*
   ii. Common knowledge
   iii. Violation of a statute (EMTALA, COBRA)
   iv. Medical literature, product inserts
   v. *Res Ipsa Loquitur* — “the thing speaks for itself” (example: foreign body left after surgical procedure)

E. Causation

1. Actual cause — direct causal relationship between negligent act and the injury (example: surgical sponge and heart attack). Also called the “But For” test — “but for” negligence, injury would not have occurred
2. Proximate cause — direct temporal relationship between the negligent act and the injury (example: spinal tap and meningitis 9 months later)

F. Damages

1. There must be compensable damages or injury to the plaintiff (i.e., “no harm, no foul”)
2. Probably most important aspect in determining whether or not an attorney will file a malpractice case against you

G. Common malpractice allegations (PIAA 1985-1999)

1. Failure to diagnose (accounts for more than half of all claims)
2. Failure to properly perform procedures
3. Delay in performing procedure
4. Failure to properly treat
5. Failure to refer/obtain consult
6. Failure/delay in admission
7. Failure to inform/lack of informed consent
8. Medication errors

H. Affirmative defenses

“Even if everything the plaintiff alleges is true, the physician still wins”

1. Statute of limitations – Medical malpractice suit must be filed within a certain period time after the negligent act or else suit is forever barred
   a. Generally, 2-4 years from time patient knew or should have known of injury — VARIES BY STATE
   b. Statute may not begin to run for minors until age 18
2. Good Samaritan laws – Exist to some degree in all states
   a. Provide a health care worker a defense when he provides *gratuitous* care where he has no legal obligation to treat
   b. Care must still be reasonable – may still be liable for gross negligence
3. Contributory negligence – A patient whose acts contribute to his own injury should not be allowed to recover
   a. If patient more than 50% liable for injury – no recovery
   b. If patient less than 50% liable – reduced recovery
   c. Theory may only be applied *prospectively*
   d. In emergency medicine, generally applies when patient fails to follow physician’s recommendations
4. Immunities – Certain physicians afforded absolute or qualified immunity from lawsuits based on nature of their practice
   a. Charitable – Volunteers not liable/limited liability or would not provide services
   b. Governmental – Can only sue government employees under certain circumstances
   c. Statutory – Local governmental and Governmental Employees Tort Immunity Act (Only liable for negligent or wrongful prescription or administration of treatment – 745 ILCS 10/6-105)

II. INTENTIONAL TORTS

Intent is defined as the desire to cause certain consequences by an act or believing the consequences are substantially certain to result from an act.

A. Special considerations for intentional torts

1. Expert witnesses not needed to establish standard of care
2. May subject defendant to civil and criminal liability
3. Physician can be liable without physical injury to patient
4. Often not covered by malpractice insurance
5. Accusation of intentional tort may be sufficient to terminate physician’s employment contract

B. Assault

1. Intending to cause and actually causing the perception of a harmful touching without consent
2. Examples:
   a. Person running up behind you in parking lot may not intend to cause perception you will be mugged. Person may just be late for dinner ⇒ no assault
   b. Person who intentionally points gun at you wants you to think you will be shot ⇒ assault with deadly weapon
c. Medical personnel may be accused of assault for threatening to perform some unjustified and/or harmful act on patient such as punishing patient by cutting the patient with a scalpel blade or threatening any actions with sexual overtones

C. Battery

1. Intending to cause and actually causing harmful physical contact without consent
2. Often arises with lack of informed consent or going beyond scope of consent
3. Examples:
   b. Using anesthetic specifically prohibited by patient (see *Schwaller v. Maguire*, 2003-Ohio-6917)
   c. Different surgeon than one authorized by patient performs surgery (*Watkins v. Cleveland Clinic*, 719 N.E.2d 1052)
   d. Intubation of DNR patient (*Leach v. Shapiro*, 489 N.E.2d 1047)

D. Invasion of privacy

1. Disclosing confidential information learned within the physician-patient relationship to a third party
2. Invasion of privacy actions now overshadowed by HIPAA
3. Important to note that some states have statutory duty to disclose certain information:
   a. Communicable disease
   b. Child/elder abuse
   c. Disabling illnesses (seizures to DMV)
4. May also have duty to protect third parties when a patient presents threat of imminent danger to a specific third party (*example*: psych patient threatens to murder wife)

E. False imprisonment (uncommon)

1. Confinement within boundaries fixed by another person without consent and without reasonable means of escape
2. Usually an issue with improper psych commitments or improper use of restraints

III. ROLE OF THE MEDICAL RECORD

“Rats desert a sinking ship – your chart is your lifeboat”

A. Reasons for medical chart:
1. Provide continuum for further care
2. Support healthcare provider’s actions/plans
3. Provide basis for reimbursement
4. Reflects history, physical findings, physician thought processes, recommended treatment, response to treatment, patient actions – “paint a picture”
5. Generally taken as fact by juries and parties to litigation
6. Incomplete or scant records may reflect poorly on physician

B. Good ideas

1. Make records legible
2. CMS requirement for conditions of participation
3. Create complete records
4. Incomplete records decrease reimbursement
5. May be basis for EMTALA violation if unable to determine care rendered
6. Read nurse’s notes - often be considered as fact

C. Bad ideas

1. Personal comments about patients
2. Quickly checking all “normals” in templates
   a. A+Ox3 in infants
   b. Bilateral pedal pulses in BKA amputee
3. Criticism of other provider’s care
4. Destroying any part of medical record
   a. Missing data can be used as presumptive evidence that something was wrong and is being hidden. Example: patient receives bill for EKG, but no EKG is found in chart
5. Changing the chart without specific notations
   a. Intentionally altering or destroying medical records after notice of suit may subject physician to punitive damages, loss of insurance, loss of license, and/or criminal charges
   b. If changing an entry in the medical record, draw a single line through incorrect entry, add date and initials, and consider noting reason for change
   c. Realize that computerized medical records often track changes and times that changes were made

D. Discharge instructions

1. Summarize physician thought processes
2. Provide patient with treatment plan (if any)
3. Provide patient with reasons/need to seek further care
4. Create patient duty to follow physician’s advice
E. “Do Not Use” list of abbreviations

1. Created by JCAHO in order to reduce medication errors
2. Include the following:
   a. “U” for “unit”
   b. “IU” for “International Unit”
   c. “QD” for “every day”
   d. “QOD” for “every other day”
   e. “MS” for magnesium sulfate or morphine sulfate
   f. “MSO4” and “MgSO4” for magnesium sulfate or morphine sulfate
   g. Trailing “zeros” and lack of leading “zeros” when writing numbers.
3. Additional requirements being proposed each year

IV. MALPRACTICE INSURANCE

A. Occurrence-based coverage – coverage depends on when incident “occurred”

1. Protects physician against negligent acts that occurred while the insurance was in effect
2. Makes no difference whether policy is in effect when claim was filed
3. Difficult to obtain commercially – usually found in “self-insured” trusts

B. Claims-made coverage – coverage depends on when “claim was made”

1. Most common form of malpractice insurance
2. Protects physician against negligent acts that occurred while the insurance was in effect ONLY if the insurance policy is still active
3. If policy lapses due to non-payment, no coverage even if negligent act occurred while insurance was in effect
4. Insurance carrier must generally be aware of event before coverage is effective

C. “Tail insurance”

1. Also called “extended reporting coverage”
2. Additional insurance that provides protection when claims-made policy lapses
3. Cost – usually 200% to 300% of mature annual premium
4. Claims-made policy + tail insurance = occurrence-based policy
5. Standard provision in emergency medicine contracts to have tail
D. “Nose insurance”

1. Extended reporting coverage, but instead of being paid at the end of your current employment (“tail” insurance), is paid at the beginning of subsequent employment by new employer
2. Quite uncommon unless remain with same insurer

E. Insurance limits

1. Limits expressed as maximum amount insurer will pay per incident and maximum amount insurer will pay per annum
2. Generally adequate limits are “$1 million/$3 million” coverage, meaning that insurer will pay maximum of $1 million per incident and maximum of $3 million per year for all cases
3. May obtain coverage with limits as little as $100,000/$300,000 or as much as $5 million or more per incident

F. Caveats

1. Medical malpractice insurance likely excludes and may be voided for intentional acts, fraudulent acts, or criminal acts
2. Medical malpractice policy may exclude or be voided due to contractual liability (indemnification clauses)

V. CONSENT

A. Types of consent

1. Express consent – Oral or written agreement between parties with full disclosure of information
2. Implied consent – Consent is implied by patient’s actions (example: rolling up one’s sleeve when nurse informs you of injection)
3. Emergency consent – Type of implied consent that occurs when a patient is incapable of giving consent but requires immediate emergency treatment.
   a. Physician generally may provide reasonable medical care as law assumes the patient would have given consent

B. Informed consent

1. Capacity – Law generally presumes that patients are competent until convincing evidence to the contrary
   a. Legal capacity
      i. Generally have legal capacity at 18 years old
      ii. Exceptions – certain minors may have legal capacity to
consent:
- Emancipated minors (see below)
- Other statutory exceptions (see below)

b. Mental (clinical) capacity
   
   NOTE: Lack of clinical capacity may be temporary

   i. Clinical capacity generally includes ability to:
      - Act on one’s own behalf
      - Understand information presented
      - Appreciate consequences of acting (or not acting) on that information
      - Make a rational decision

   ii. Clinical capacity may be affected in many ways:
      - Intoxicants
      - Metabolic problems
      - Psychiatric problems/dementia
      - Head injury

c. Important to clearly document reasons for/against capacity

2. Information provided
   a. Discussion of procedure, medication or test
   b. Purpose
   c. Procedure
   d. Risks
   e. Alternatives to proposed action
   f. Patient may discontinue at any time
   g. Information should include information reasonable person would want to know PLUS any specific information patient asks about (complication rates, physician experience, etc.)

3. Consent
   a. “Patient knowingly and competently assumes the risks of that treatment”
   b. Signed consent form helpful, not necessary – creates rebuttable presumption” that consent was informed
   c. CONSENT MAY BE WITHDRAWN AT ANY TIME IN ANY MANNER

4. Caveats
   a. Court retrospectively determines capacity when question arises – documentation important
   b. Signed consent form ≠ informed consent
   c. Informed consent does not absolve liability for negligent acts

VI. MEDICAL TREATMENT OF MINORS

EMTALA allows any minor to request and receive a medical screening examination and stabilizing treatment for an emergency medical condition regardless of whether consent has been received from parents.
Once patient has been stabilized, consider halting further treatment until parental consent can be obtained

A. Emancipated minor – May not need consent to treat minors who are no longer under parental control (criteria vary by state):

1. Marriage
2. Pregnancy
3. Parent
4. Military service
5. High school graduate
6. “Mature minors” – capable of understanding risks/benefits of treatment and making rational decision yet less than 18 years old

B. Other exceptions

1. Due to public policy concerns, may not need consent for minors who seek treatment for specific health problems (criteria vary by state):
   a. Drug or alcohol addiction/abuse
   b. Sexually transmitted diseases
   c. Birth control
   d. Physical or sexual abuse

C. Parents patriae – “Country as parent” (see, e.g., In re E.G., a Minor, 549 N.E.2d 322, Commonwealth v. Nixon, 761 A.2d 1151)

1. A parent cannot refuse needed medical care for children or incompetent patients. This doctrine allows the state to represent the best interest of the child
2. Child abuse and neglect statutes also allow physicians and hospitals to take protective custody when the child needs medical care
3. Determination of whether to take custody often dependent on severity of illness (example: URI vs. transfusion/sepsis)

VII. MEDICAL TREATMENT OF INCOMPETENT PATIENTS

A. Competent patients may refuse care

B. Right to refuse care is a balance between patient’s right to self-determination and state’s interest in protecting the lives and safety of its citizens (example: citizens have no right to commit suicide)

C. Patients have greater autonomy to refuse care when ramifications are minor (minor laceration) than when ramifications are major (acute MI) or involve children/incompetent family members
D. If patient is deemed incompetent/intoxicated/unresponsive:

1. Consider bargaining with incompetent yet conscious patients
   a. Give patient a meal
   b. Call family/patient’s physician
   c. Allow patient to leave in an hour if still feeling same way
2. Search for advance directives
3. Search for surrogate decision maker
   a. Power of attorney
   b. Family
   c. Friends
   d. Personal physician
4. If unable to determine patient’s wishes or find surrogate decision maker, must do whatever you believe is in patient’s best interests
5. Incompetent patients may require physical/chemical restraints for medical treatment (IV lines, catheters), to protect themselves, or to protect medical staff

E. Note that patients may not remain incompetent

1. Intoxicants may become metabolized/neutralized
2. Metabolic problems may be corrected
3. Psychiatric problems may be controlled with medication

F. If doubt over competency, consider psychiatric evaluation

G. If questions persist, involve hospital administration

H. Pearls in treating incompetent patients

1. Ultimate determination of competency made by courts in retrospective review. Documentation extremely important!
2. If patient appears incompetent, document specific reasons why: “patient has slurred speech, nystagmus, and staggering gait” as opposed to “the patient is drunk”
3. Disagreement with physician ≠ incapacity or incompetence
4. If competency is in doubt, provide appropriate treatment until definitive determination can be made

VIII. USE OF RESTRAINTS

Indirectly governed by CMS Conditions of Participation (42 CFR 482.13)

A. U.S. Supreme Court decision permits use of restraints [Youngberg v. Romeo, 457 U.S. 307 (1982)]

1. Use of restraints must balance patient’s right to freedom of
movement with institution’s right to protect workers and others from violence
2. Professional decision to use restraints for safety or to provide needed training “presumptively valid”
3. “Courts must show deference to the judgment exercised by a qualified professional”

B. Restraints include:

1. Physical restraints – any manual method or physical material that restricts freedom of movement or normal access to one’s body
2. Drugs as restraints – medication used to control behavior or to restrict freedom of movement that is not a standard treatment for patient’s medical or psychiatric condition
3. Seclusion – involuntary confinement of a person in a room or an area where the person is physically prevented from leaving

C. General rules

1. Written order from physician required; cannot be standing (“PRN”) order
2. Entry of restraint order must be followed by consultation with treating physician unless treating physician initiated order
3. Restraints must be implemented in the least restrictive manner possible and in accordance with “safe and appropriate restraining techniques”
4. Patient’s condition must be “continually” assessed, monitored, and reevaluated
5. Restraints must be ended at the earliest possible time
6. Hospital staff must have training in application, monitoring, and safety of restraint use
7. Any deaths related to restraints or while patients are in restraints must be reported to CMS

D. Restraints necessary for medical care

1. May only be used if needed to improve the patient’s well-being and when less restrictive interventions have been determined to be ineffective

E. Behavioral restraints

1. May only be used in emergency situations if needed to ensure physical safety of patient or staff and less restrictive interventions have been determined to be ineffective
2. Each written order for a physical restraint or seclusion is limited to:
   a. 4 hours for adults
b. 2 hours for children and adolescents ages 9 to 17
   c. 1 hour for patients under 9
3. Patient must be evaluated by a physician or licensed independent practitioner within 1 hour after behavioral restraints initiated
4. Restraints and seclusion may not be used simultaneously unless patient is:
   a. Continually monitored face-to-face by a staff member
   b. Continually monitored by staff using both video and audio equipment in close proximity the patient

IX. ADVANCE DIRECTIVES

A. Allow patients to direct their care in the event that they become unable to provide direction to health care workers (mental status change or unconsciousness)

B. Orders do not apply to competent patients!

C. Patient desires should trump family desires

D. Durable power of attorney

   1. Legal document used in some states to specify an agent to make health care decisions on behalf of patients
   2. Generally, patients state their preferences and make specified limitation on their agent’s powers
   3. Becomes effective when patients are no longer able to make their own health care decisions

E. Do Not Resuscitate order

   1. Type of advance directive relating only to withholding life-sustaining treatment in permanent and irreversible condition
   2. Distinction between medical treatment, comfort care, and life-sustaining treatment sometimes difficult
   3. DNR ≠ Do Not Treat (EMTALA concerns)

F. Most states provide immunity for physician acting or failing to act based on good faith beliefs regarding advanced directives

G. Advance directives are immediately revocable if patient expresses a desire to revoke them!

X. HIPAA OVERVIEW

A. Definitions

   1. Protected Health Information (PHI) – individually identifiable
demographic data relating to provision of health care to individual (name, address, DOB, SSN). Data which could reasonably be used to identify an individual.

2. Covered entities – any health care provider that furnishes, bills for, or is paid for health care services

B. Privacy rule

1. PHI in any form (electronic, paper-based, oral) may not be disclosed unless:
   a. Required disclosures
      i. Requested in writing by individual or representative
      ii. CMS compliance investigation
   b. Permitted disclosures (not required)
      i. Treatment, payment, health care operations purposes IF relationship with patient
         • “Operations” include QI, audits, legal services, insurance underwriting, administrative activities
         • Obtaining consent optional for covered entities
         • Disclosures generally permitted during emergency situations and unavailability of representative
      ii. Public interest
         • Required by law (court orders)
         • Law enforcement purposes (to identify victim, suspect, witness or to report crime)
         • Serious threat to health or safety of public or individual
         • Public health activities
         • Other (research, funeral directors, organ donation, etc.)
      iii. Opportunity to agree or object to disclosure
         • Asking the individual outright
         • Circumstances that clearly give the individual the opportunity to agree, acquiesce, or object
         • In an emergency situation

2. Authorization must be specific, identifying covered entity or third party to whom disclosures may be made

3. Use and disclosure of PHI must consist of only the minimum necessary information to achieve the purpose at hand except for disclosures by health-care providers for treatment purposes

4. HIPAA does not apply to de-identified information

C. When faxing information, must verify identity of party receiving fax and provide ongoing monitoring of fax security

D. Patients have right to review records, change records, receive notice of past PHI disclosures
E. Only Secretary of Health and Human Services or (through HITECH Act) State Attorney General may bring action against provider under HIPAA. No private right of action.

F. Fines for noncompliance (increased under HITECH Act):
   1. $100 per violation up to $25,000 per year
   2. Up to $50,000 for “willful neglect” that results in disclosure of PHI
   3. Up to $100,000 and 5 years imprisonment for wrongful disclosures of PHI under false pretenses
   4. Up to $250,000 and 10 years imprisonment if wrongful disclosure made with the intent to use PHI for commercial advantage, personal gain, or malicious harm

XI. EMTALA

A. Definitions

1. “Comes to the hospital” – a patient who is anywhere on hospital property or within 250 yards of the main hospital is protected by EMTALA
2. “Medical Screening Examination” – a hospital must uniformly provide an appropriate medical screening examination (MSE) reasonably calculated to determine whether an Emergency Medical Condition (EMC) exists
3. Emergency Medical Condition – an EMC means a patient with acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in placing the individual’s health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part
4. Appropriate Transfer – four requirements:
   a. The transferring hospital has utilized all of its resources in trying to stabilize the EMC
   b. The transferring hospital must obtain permission and assurance from the receiving hospital that it has available space and qualified personnel for treating the EMC and document this including the name of the person accepting the transfer
   c. Necessary medical records and test results must be made available to the receiving hospital
   d. The transfer must be made with qualified personnel and equipment
B. EMTALA’s three basic requirements:

1. Medical Screening – Any individual who comes to the hospital requesting care for a medical condition (or who a prudent layperson would believe needs medical care) must be provided an appropriate MSE
2. Stabilization - If the MSE reveals an EMC, then the hospital must use all of its resources to stabilize the EMC
3. Transfer - If the hospital cannot stabilize the EMC even after utilizing all of its resources, the hospital may transfer the patient if each of the following are satisfied:
   a. Benefits of transfer outweigh the risks
   b. The patient consents to the transfer after being informed both of the risk and benefits of transfer
   c. The transfer is “appropriate”
4. EMTALA duty ends once patient is admitted or arrives at accepting hospital

C. EMTALA duties end when

1. EMC has resolved
2. Patient is transferred and arrives at another hospital

D. EMTALA penalties

1. Physicians:
   a. Civil money penalty of up to $50,000 for each violation
   b. Terminate a practitioner from the Medicare program if the physician’s EMTALA violation is gross and flagrant or if there are repeated violations
   c. Physicians are not sued directly under EMTALA – they are fined
2. Hospitals:
   a. Civil money penalty of up to $50,000 for each violation ($25,000 for hospitals with fewer than 100 beds)
   b. Terminate a hospital from the Medicare program
   c. Any individual who suffers personal harm as direct result of a hospital’s violation of EMTALA may file a civil suit against the hospital

XII. FAMILY VIOLENCE

A. Intentional intimidation; physical/sexual abuse or battering of a person by a family member, intimate partner, or caretaker

B. Applies to abuse and/or neglect of children, adults, and elders
C. Mandatory reporting

1. Each state requires child abuse to be reported to authorities
2. Some states require reporting of elder abuse
3. Physician who knowingly fails to report suspected abuse under mandatory reporting laws can be charged with a misdemeanor

D. Immunity

1. All child abuse statutes provide immunity from liability for physicians who report suspected child abuse
2. Some states provide absolute immunity while others require “good faith”

E. May be liable for medical malpractice if child sustains injury due to failure to report
MEDICAL LEGAL

PEARLS

1. Four elements of negligence: duty, breach, causation and damages.

2. Breach of duty: Failure to exercise the skill, care and knowledge that reasonably well-qualified practitioner in the same specialty would apply under the same or similar circumstances. Determined by expert testimony in most instances.

3. Defenses to negligence: Statutes of Limitations, Good Samaritan Laws.

4. Contributory negligence, immunities.

5. Express consent: Oral or written agreement by patient.

6. Implied consent: Patient voluntarily submits to treatment without oral or written consent (rolling up sleeve for blood draw).

7. Informed consent - Patient must understand all the reasonable risks and benefits inherent in a treatment or procedure. Patient must be competent to make decision. Not an excuse for physician to perform negligently.

8. Minors eligible to provide consent under certain circumstances: married, pregnant, parent of a child, military service. Some states allow minors to consent for treatment of drug/alcohol abuse, physical/sexual abuse, STDs.

9. Against Medical Advice: Properly completed AMA forms should show the process of determining patient’s decision-making capacity and that the patient has been fully informed of the risks, benefits, and alternatives to treatment. AMA forms do not provide immunity in malpractice suits.

10. Living will: Legal document directing health care staff on treatment preferences of patient when patient is unable to make this decision. Living wills may be revoked at any time. DNR doesn’t mean “do not treat”.

11. Durable Power of Attorney: Legal document used in some states to specify an agent to help patients make health care decisions when patients are no longer capable of making decisions by themselves. Patients may limit agent’s powers.

12. Intentional torts: Assault - reasonable fear of harmful touching without consent (pointing gun).

14. False imprisonment: Intentionally detaining in an unlawful manner otherwise restricted in movement without consent.

15. Invasion of privacy: Legitimate privacy interests of patients are publicized to third parties. May have statutory duty to disclose communicable diseases, child abuse, disabling illnesses (seizures to DMV).

16. Defamation: Injury to reputation caused by communicating a false statement to third parties.

**HIPAA**

17. Use of protected health information (PHI) in any form must involve only minimal information necessary to achieve purpose at hand except when relating to treatment of patient.

18. Must provide ongoing monitoring of fax security.

19. Patients have right to review records, change records, receive notice of PHI disclosures.

**EMTALA**

20. EMTALA’s three basic requirements:
   - Medical Screening – Any individual who comes to the hospital requesting care for a medical condition must be provided an appropriate Medical Screening Examination (MSE)
   - Stabilization - If the MSE reveals an Emergency Medical Condition (EMC), then the hospital must use all of its resources to stabilize the EMC
   - Transfer - If the hospital cannot stabilize the EMC even after utilizing all of its resources, the hospital may transfer the patient.

21. Medical Screening Examination: Hospitals must provide uniformly appropriate MSE reasonably calculated to determine whether an EMC exists.

22. Penalties for EMTALA violations for hospitals:
   - Civil money penalty of up to $50,000 for each violation ($25,000 for hospitals with fewer than 100 beds)
   - Termination from Medicare program

23. Penalties for EMTALA violations for physicians:
   - Fines of up to $50,000 for each violation. No lawsuits can be
brought against physicians
  • Termination from Medicare program if flagrant or repeated violations

24. Malpractice insurance
  • Occurrence-based – covered if insurance effect when negligence occurred
  • Claims made – covered if insurance in effect both when negligence occurred and when claim was made
  • Claims made policy + tail insurance = occurrence-based policy

**Family violence**

25. Physicians and medical staff are mandated reporters.

26. Physician who knowingly fails to report suspected child abuse can be charged with a misdemeanor and may be liable for malpractice if injury results from failure to report.

27. Reporters have immunity from liability when making reports in good faith.
REFERENCES


6. Department of Health & Human Services, HIPAA Information Site (http://www.hhs.gov/ocr/hipaa)


9. Interpretive Guidelines: Responsibilities of Medicare participating hospitals in emergency cases - guide to site surveyors. 42 C.F.R. § 489.10 June 1, 1998.

10. Legal Medicine, Legal Dynamics of Medical Encounters. 2nd ed., American College of Legal Medicine, 1991.


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