

# the Reporter

## EMTALA: requirements and compliance guidelines

by Lynne Dakers, JD, Risk Management Representative

The Emergency Medical Treatment and Active Labor Act (EMTALA) <sup>1</sup> was passed by Congress in 1986 and governs the delivery of hospital-based emergency medicine, granting federal rights to individuals and other hospitals for violations of the act. Originally intended to prevent “dumping” of medically unstable, indigent patients, it has metamorphosed via the Centers for Medicare and Medicaid Services (CMS) regulations and court cases into what some now call America’s “national health care system.” <sup>2</sup> Unfavorable CMS regulations, court decisions <sup>3</sup> and the incorporation of EMTALA violations into medical malpractice cases <sup>4</sup> have caused many physicians to avoid taking emergency call or to drop emergency call rotation completely. What follows is a brief overview of EMTALA and what it requires of physicians.

### EMTALA requirements

1. Medical screening examination to determine if an emergency medical condition exists.
2. If an emergency medical condition exists, the hospital must either stabilize the medical condition or transfer the patient to another hospital that is capable of stabilizing the medical condition. <sup>5</sup> Hospitals must provide on-call physicians to help stabilize patients.
3. Hospitals with specialized capabilities or facilities (e.g., trauma, neonatal intensive care or burn treatment centers) must accept appropriate transfers of patients who require specialized services if the hospital has the capacity to treat the individual. <sup>6</sup>

Probably the most important thing a hospital can do for EMTALA compliance is to have and follow a consistent, non-discriminatory process for screening and transfer. The most common reason for EMTALA citations against a hospital is the failure of the institution to follow its own protocols and procedures for compliance. <sup>7</sup>

Most EMTALA cases against physicians involve doctors who refuse to treat emergency patients before receiving authorization from the patients’ managed care plans or on-call physicians who fail to respond to treat emergencies. <sup>8</sup>

### Duties of on-call, admitting and consulting physicians

EMTALA requires all specialties and subspecialties generally available in the hospital to participate in the on-call schedule, requiring a minimum call rotation of the physicians, usually 10-15 days per month. Where a hospital has only one or two specialists on staff, some nights may not be covered. An issue arises where privileged physicians refuse to take call. If a hospital does not put a physician on-call and that specialty is not covered by other physicians, it is subject to an EMTALA violation. Where the hospital can cover call with other physicians, the matter of call coverage becomes a contract issue. However, if it cannot cover call, it becomes an EMTALA issue. CMS would expect their privileges to be revoked.

## Inpatients

Any patient admitted through the emergency department and later discharged from the hospital has been “transferred” according to EMTALA, therefore all the transfer requirements of the law apply, that is, the patient is stable upon discharge.

CMS site review guidelines do not prevent normal physician-patient contact on “off” days. They provide:

1. Just because the physician is in-house seeing a patient does not make the physician responsible for call when he or she is not on-call.
2. A physician may be on-call for his or her own patients even when not on-call for the hospital.
3. A physician may voluntarily respond to a request for assistance when not on-call without creating an obligation to continue to do that in the future.<sup>9</sup>

## On-call duties

EMTALA does not directly mandate that physicians take call. Rather, their duties attach by virtue of accepting staff privileges at a Medicare-participating hospital. By agreeing to participate in on-call ER coverage in the bylaws and departmental rules and regulations, physicians voluntarily accept EMTALA responsibility. CMS regulations require that physician specialties generally available to patients at a participating hospital are also available for treatment of patients presenting to the emergency department.<sup>10</sup>

The on-call list is maintained by the hospital and medical staff and must be immediately updated to reflect any changes in physician staffing. Physicians whose names appear on the on-call list are responsible for finding a suitable replacement if they cannot be available for duty and for updating the on-call list with the replacement physician's name and other appropriate information.<sup>11</sup>

An on-call physician's responsibilities are triggered by the emergency room physician, and he or she must respond in a reasonable period of time. Again, medical staff bylaws or policies and procedures define the responsibility of on-call physicians to respond, examine, and treat patients with emergency medical conditions. Hospital policies must also address situations where a particular specialty is not available or on-call physicians cannot respond because of situations beyond their control.<sup>12</sup> On-call physicians who may be on-call at another hospital must not request that a patient be transferred to the second hospital for the physician's convenience. Under no circumstance should a patient be transferred for the convenience of the physician.<sup>13</sup>

## Responsibilities for follow-up

Where the on-call physician is office-based, it is not acceptable to refer emergency cases to their office for examination and treatment. The physician must come to the hospital to examine the patient unless the physician's office is a hospital-owned facility on contiguous land or on the hospital campus.

Where an emergency room patient has been given discharge instructions that provide the name of the on-call physician (or one required by medical staff bylaws to see in follow up), refusing to see these patients for financial purposes (e.g., the patient had previously been discharged from the practice for failure to pay) could lead to a CMS complaint. According to Stephen Frew, JD, these types of circumstances have resulted in citations for several different reasons:<sup>14</sup> 1) the on-call should have been called in, and this “deferred” stabilizing care; 2) the state or hospital rules required the follow up visit, therefore the MD was required to provide the care; or 3) the discharge was as a “plan of care” discharge under the rules, and the on-call violated the plan of care.<sup>15</sup>

## Conclusion

As mentioned above, physicians' on-call responsibilities are defined by hospital bylaws, rules and regulations. In order to ensure EMTALA compliance, physicians must be aware of these policies.

The Office of Inspector General has drafted a Compliance Program for Individual and Small Group Physician Practices,<sup>16</sup> finding physician on-call responsibilities to be an area of particular concern. It recommends that “physician practices whose members serve as on-call emergency room physicians with hospitals should make sure they are familiar with the hospital's policies regarding on-call physicians. This can be done by reviewing the medical staff bylaws or policies and procedures of the hospital that must define the responsibility of on-call physicians to respond to, examine, and treat patients with emergency medical conditions. Physicians should also be aware that, in most cases, on-call physicians must come to the hospital to examine the patient when a request is made for their services.”

Physicians and/or their office managers should maintain copies of the medical staff bylaws and/or medical staff rules and regulations for all hospitals with which the practice's physicians maintain privileges. These should be kept in a common place and readily accessible. If necessary due to the number of hospitals served, prepare a chart of various hospitals' requirements for on-call physicians and make sure physicians in the practice who take call are aware of the on-call response requirements.

## References

1. 42 U.S.C. 1395dd.
2. *amednews.com*. The Ever-expanding EMTALA. April 23/30, 2001.
3. A 1999 U.S. Supreme Court opinion (its first ruling on EMTALA) holding that an improper motive need not be shown for EMTALA stabilization and transfer cases. 119 S. Ct. 685, 525 U.S. 249.
4. Under EMTALA, doctors are already subject to up to a \$50,000 fine for each violation and possible exclusion from the Medicare program. EMTALA provides a private right of action against a hospital for an EMTALA violation, but there is no private right of action against a physician for an EMTALA violation.
5. Patients may not be transferred until their condition is stable, however, unless the expected benefits of transfer outweigh the risks or the patient requests to be transferred.
6. A receiving hospital may decline a patient if the individual being suggested for transfer does not require care beyond that available at the transferring hospital.
7. Challenges in the Delivery of ED Care Under COBRA/EMTALA Requirements. *RMF Forum*. Copyright 1996-2001.
8. EMTALA Charges Against MDs Increase. *Medical Malpractice Law & Strategy*. August 1999. If it is necessary to transfer a patient because an on-call physician failed or refused to come in, the emergency physician must list the name and address of the on-call physician in the transfer documentation, resulting in the receiving hospital reporting the incident for investigation.
9. [www.medlaw.com/EMTALA/messages/371.html](http://www.medlaw.com/EMTALA/messages/371.html).
10. The on-call list must include every specialty privileged in the hospital, unless too few physicians exist in a specialty to provide coverage (special rules apply). COBRA/EMTALA Resources Frew Consulting Group, *medlaw.com*. April, 2001.
11. EMTALA Quick Reference Guide for On-call Physicians. American Medical Association. Copyright 1995-2001.
12. On-Call Responsibilities for Hospitals and Physicians. American College of Physicians Quality Advisory. Copyright 1996-2001.
13. *Ibid*.
14. Although Frew does note that this is an uncertain area of the law, he points out that an investigation could make a physician vulnerable to other violations, regardless of whether the initial complaint is viewed as a violation.
15. However, if the directions for follow-up do not refer the patient to a specific MD, and assuming no prior contact regarding this from the ED, then it would be acceptable to ask for payment up front.
16. *Federal Register*. June 12, 2000; 65 (113).

# On-call liability issues for physicians



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by Lynne Dakers, JD, Risk Management Representative

For a variety of reasons, physicians must either be personally available to their patients 24/7 or provide for adequate coverage.<sup>1</sup> Those physicians who belong to large group practices are fortunate in that they can look to their partners and/or associates for these arrangements. Typically, physicians practicing together share practice philosophies, are of the same specialty, have more open avenues of communication and feedback, and may even be familiar with each other's patients. Even in this situation and more especially where it is obtained outside a group, after-hours coverage presents physicians with several potential risks which will be explored below.

Quite probably the most cited reason for obtaining after-hours coverage is to protect oneself against allegations of negligence in the form of abandonment. Abandonment usually is defined as "the unilateral severance of the professional relationship . . . without reasonable notice at a time when there is still the necessity of continuing medical attention."<sup>2</sup> Proof of abandonment requires showing that the physician failed to provide an "adequate medical attendant," failed to give reasonable notice, and, as in any negligence action, that the plaintiff suffered an injury as a result. The physician's responsibility is therefore to be available to provide medical attention for his/her patients. When not available, the physician must provide for adequate coverage, which in most cases is a physician of similar skills, training, and experience.

There can be instances where a physician can face both civil liability and federal law violations<sup>3</sup> even where he or she has not established a physician-patient relationship, such as through a managed care contract<sup>4</sup> or hospital on-call responsibilities.<sup>5</sup> Therefore, a physician may be found liable if he or she does not respond to an emergency call, does not provide reasonable notice to the hospital when he is not available, or arranges for a replacement that is not qualified to provide the same services.<sup>6</sup>

Coverage by an equally skilled physician is required not only to protect against allegations of abandonment or violations of EMTALA, but also to protect the physician against other negligence actions. Certainly should a patient suffer an injury as a result of actions or

inactions taken by on-call coverage, the physician can expect to be brought into the suit either with allegations of comparative negligent treatment of the same condition or under an agency theory similar to that of "negligent referral."<sup>7</sup>

Providing for coverage by an equally skilled physician is not enough, however, to ensure your patients will be cared for appropriately in your absence. Issues of communication (including access to patient records), documentation, and patient satisfaction are also important considerations.

Communication between physicians who share call is important to provide competent medical care. Physicians should take the time to relate to their coverage those patients who may require care in their absence. Arrangements should be made for access to medical records, including patient demographic information, if necessary. Should a covering physician give medical advice or assistance after-hours, this information must be relayed to the primary physician and documented in the patient's medical record. The covering physician may also want to retain documentation of this encounter in the event that the information sent to the primary physician becomes misplaced or misfiled.<sup>8</sup>

Patients must be made aware of the physician's after-hours arrangements. This can be done by referring to the arrangements in your practice brochure. Should the call group have certain policies, such as not refilling prescriptions or prescribing narcotic medications after-hours, these policies should be clearly communicated to your patients. It may be beneficial when performing a patient satisfaction survey to elicit patient comments with regard to your call coverage and act on these accordingly.

While the above issues may not be exhaustive on the subject and court decisions may continue to create new or broader areas of liability, it is nonetheless essential for the prudent physician to be cognizant of the potential risks associated with after-hours arrangements and to act accordingly. As this article suggests, risk adverse physicians are encouraged to consider the potential hazards of inadequate coverage as well as to become familiar with the obligations placed upon them by hospital bylaws and managed care contracts.

## References

1. Some physicians elect to rely on hospital emergency care for after-hours coverage. The risk management implications of such an arrangement are beyond the scope of this article.
2. *Lee v. Dewbre*, 362 S.W.2d 900, 902 (Tex Civ App-Amarillo 1962, no writ).
3. Emergency Medical Treatment and Active Labor Act (EMTALA), 42 U.S.C. 1395dd.
4. *Hand v. Tavera*, 864 S.W.2d 678 (Tex App-San Antonio, 1993).
5. The Texas Supreme Court, in *St. John v. Pope*, 901 S.W.2d (Tex. 1995) held that the mere fact that a physician is "on call" does not in itself impose any duty to patients. In dicta, however, the court noted that a physician may agree in advance to the creation of a physician-patient relationship through an agreement with a hospital.
6. *Evading an Emergency Call Can Put Doctors in Legal Peril*. *Am Med News*. January 24, 2000.
7. Whereby a referring physician may be liable when the care provided by the other physician, usually a specialist, falls below the standard of care.
8. It is recommended that this information be stored in a way as to make it retrievable (that is, by date or patient name) and that it be retained for at least the length of time covered by the statute of limitations for health care liability claims — generally, for adults, two years from the date medical treatment is completed.

# Clinical trials on trial



by Lynne Dakers, JD, Risk Management Representative  
and Laura Hale

In 1997, President Bill Clinton issued an apology to the survivors and families of 399 black men who were part of the United States Public Health Service's Tuskegee Syphilis Study.<sup>1</sup> The men were told they suffered from "bad blood," and were enrolled in what they believed to be a treatment program. In actuality, they were part of an observational research study designed to monitor the progression of un-treated syphilis. In exchange for their participation, the men received free meals, free medical examinations and burial insurance. Even though rudimentary treatments for syphilis were available when the study began in 1932, the men were never treated for the disease. The study did not end until 40 years later, 20 years after penicillin had been identified as an effective treatment for syphilis.<sup>2</sup>

This was the second time during his administration that President Clinton apologized for the government's role in medical research. The previous year, he apologized for the human radiation experiments that had been conducted in the United States from 1944 to 1974.<sup>3</sup> While regulatory safeguards for protecting research participants have improved significantly since these studies were undertaken, historical cases such as the Tuskegee Syphilis Study, and some recent high profile cases have increased public pressure to hold researchers and research institutions accountable for the protection of human subjects. Where are we in 2001?

From 1991 to 1998, the percentage of clinical trials performed at academic medical centers (the traditional venue) dropped from 70 to 43 percent.<sup>4</sup> An increasing number of community doctors are doing clinical research for a variety of reasons. Likely the largest incentive is monetary. In light of managed care payment constraints, now, more than ever, physicians are looking for ways to supplement their income. And while federal studies may not provide a strong monetary incentive, the revenue generated by drug company-sponsored trials does. Phase II trials pay an average of \$5500 per patient. Phase IV pays on average \$5000.<sup>5</sup> Some offer as much as \$10,000 per patient referred.<sup>6</sup> Certainly, there are other reasons to participate in clinical

research. Practitioners who engage in research not only can offer their patients alternative and arguably better therapies, their involvement in such research tends to enhance their image. Some physicians engage in research for the time-honored tradition of the advancement of science, while others may do so as a means of remaining current in their field. It is interesting to note that the attrition rate for new clinical research physicians is high with 20-25 percent quitting after one assignment. There are, however, potential risks involved. Even where physicians are not directly involved in clinical trials, they could find themselves involved in potential litigation if they refer patients to clinical trials, if they serve as primary caregivers to participants, or even if they volunteer to serve on institutional review boards. What follows is a general overview of pharmaceutical clinical trials with some risk management suggestions to physicians.

Food and Drug Administration (FDA) approval requires four phases of testing. Phase one usually involves healthy participants and a small number (20-100) of paid volunteers. In this phase, researchers look at what happens when the drug is taken: its side effects, excretion, etc. Phase two, which lasts from several months to years, involves several hundred participants and evaluates the drug's efficacy, usually by comparing the drug to a placebo. In the third phase, similar to phase two and also involving hundreds of participants, the drug's efficacy is studied in-depth. If the drug passes this third phase, a company may seek FDA approval to market it. Once approved, the drug enters phase four, where the FDA continues to monitor its use and effects.<sup>7</sup> These trials can be funded by private-sector pharmaceutical companies, nonprofit health foundations, or public institutions, such as the National Institute of Health.

While few can argue against the benefits of clinical testing, ethical and legal issues do arise since research involving human participants can create a potential conflict of interest between the physician's role as researcher and as caregiver. If the investigator is the patient's primary care physician, patients may be susceptible to real or imaginary pressure to participate. Where with academia-based physicians the potential lure towards less-than-ethical choices lies in the desire to "publish or perish," community-based physicians must guard against the influence of a highly competitive billion-dollar pharmaceutical industry. The average drug takes 12 years and \$500 million to develop.<sup>8</sup>

Patients choose to participate in clinical trials for any number of reasons, including monetary compensation. However, where payment is given to defray the incurred expense for participation, it must not be coercive in amount or method of distribution.<sup>9</sup> Patients with active disease processes may choose to participate in order to gain access to treatments not currently available. Past and recent highly-publicized tragedies, particularly the death of 18-year-old Jesse Gelsinger, who died while participating in research conducted by the University of Pennsylvania's Institute for Gene Therapy, and the death of Ellen Roche, a healthy 24-year-old participant in a NIH-funded asthma study at Johns Hopkins University,<sup>10</sup> have served to undermine public confidence in medical research. The scientific community tends to underestimate the lay community's level of concern.<sup>11</sup> Physicians can protect patients by assuring that human subjects meet study criteria, obtaining an adequate informed consent, and monitoring what happens to them. "Clinical trials frequently

recruit volunteers with active disease or conditions for which treatment is normally prescribed. Regardless of disclaimers made in the consent process, such participants often hope that the experimental therapy will improve their condition . . . consequently, the standards for protection of and disclosure to research subjects are higher than those for patient consent to medical care.”<sup>12</sup>

Public confidence is not the only variable affecting research subject participation. Concern about the privacy of health information is cited as a primary factor. In genetic studies at the NIH, nearly 32 percent of eligible people offered a test for breast cancer risk decline to take it. The overwhelming majority of those who refuse cite concerns about health insurance discrimination and loss of privacy as the reason.<sup>13</sup> Fear of being stuck with the expense of medical care also plays a factor. Many studies include in their patient consent form a provision denying patients financial compensation or reimbursement for the costs of research-related injuries. In addition, although many insurance companies do pay for routine costs of care for patients in medical trials, patients usually believe that if they join a trial, they will be hit with extra fees.<sup>14</sup> The long-awaited Patients’ Bill of Rights may, however, make this coverage mandatory as both the House and Senate bills include such a provision.

Another barrier to patient participation is that physicians are not informing patients of the option to participate in clinical trials. A recent Harris poll of patients with cancer reported that 80 percent of patients did not even know that participation was an option.<sup>15</sup> Physicians are also becoming less motivated due to time and money pressures. For example, The American Cancer Society for Clinical Oncology estimates that each trial patient costs \$3000 or more while the National Cancer Institute reimburses \$1500-2000. Privately run trials typically pay more.<sup>16</sup> Time is a factor because of the need to see more patients weighed against the extra time spent to discuss clinical trials. In addition, not every patient who is approached will agree to participate. Paperwork and data collection also cut into physician time and overhead.

The physician as researcher has his or her own unique concerns, not the least of which is what appears to be an increasingly popular cause of action from plaintiff attorneys. Spearheaded by Alan Milstein in New Jersey (who brought suit on behalf of Jesse Gelsinger against the University of Pennsylvania), plaintiffs’ attorneys are finding a new source of potential lawsuits in clinical trials. Milstein’s suits are not built on traditional malpractice theory but challenge the validity of volunteer consent to participate under the Fourteenth Amendment’s guarantee of due process. No cases have yet gone to trial. *Gelsinger v. University of Pennsylvania* was settled confidentially.<sup>17</sup> With at least 100,000 new volunteers enrolling in clinical trials each year,<sup>18</sup> it is no wonder plaintiffs’ attorneys are interested. And with the recent media attention afforded adverse events, coupled with public dissatisfaction with the health care delivery system in general, a growing number of claims, including class action suits, are likely to follow. “Litigation in the clinical trial area is definitely already on the upswing.”<sup>19</sup> Other potential plaintiffs include subjects who lose access to therapies they believe have been successful or subjects who have been expelled from a study, either through a claim or a request for injunctive relief. Recruitment techniques providing too much temptation (monetary incentives, overblown promises about the therapy’s efficacy) may also give rise to claims.

In addition, physician researchers must carefully read and, if necessary, negotiate clinical trial agreements. Typically a sponsor will engage one or more contractors to manage the study and provide administrative services. Consequently, due diligence toward all parties involved is imperative for the physician.

When signing a clinical trial agreement, look for:

- Payment — if the agreement states that compensation and

any services, staffing or facilities are to be provided by the contractor, you will not be able to look to the sponsor.

- Reports and publications — while the sponsor will likely have ownership of study reports generated by you, consider requesting the rights to obtain study data and results for publication. Should the sponsor reserve the right to review such a paper, it should not be allowed to make editorial changes or alterations to the results and conclusions.

- Confidential information — an agreement will prohibit you from disclosing sponsor trade secrets and any proprietary information. However, information that is already available to the public, already in your possession, or received from a third party, or required to be disclosed by law should not be included.

- Termination — the termination clause should allow you to end the study if you deem it necessary in order to protect the interests of the study participants.

- Indemnification — the sponsor should indemnify you from any claims, legal proceedings and causes of action (including reasonable attorney fees) relating to subject personal injuries incurred from the study. Of course, do not agree to indemnify the sponsor.<sup>20</sup>

As alluded to above, physicians may find themselves affected by clinical research even where they don’t actively participate in trials. Referring a patient to a particular trial may cause the physician to be named in any claim stemming from the patient’s participation (similar to a claim for negligent referral). Any notices that you may have in your reception area or patient literature which attempts to elicit patients to enter clinical trials, may open you to liability as well (perhaps under a *de facto* association theory). While not meant to discourage physicians from participating in clinical testing, we would encourage physicians who are either conducting trials or referring patients to do so with some discretion.

## References

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18. Milford, M. Lawsuits Attack Medical Trials. *Nat Law J*. August 21, 2001.
19. Insurance Companies Get Stricter on Clinical Trials. *cancerpage.com*. June 27, 2001.
20. Harris, S. Issues to Consider in Clinical Trial Agreements, *Am Med News*. March 27, 2000.

# closed claim studies

## Failure to conduct an adequate exam and delay in performance

by Lynne Dakers and Stacey Agnew, Risk Management Representatives

*The following closed claim study is based on an actual malpractice claim from Texas Medical Liability Trust. This case illustrates how action or inaction on the part of physicians led to allegations of professional liability, and how risk management techniques may have either prevented the outcome or increased the physician's defensibility. An attempt has been made to make the material less easy to identify. If you recognize your own case, please be assured it is presented solely for the purpose of emphasizing the issues presented.*

### Clinical presentation

A 56-year-old man presented to a new primary care physician, an internal medicine specialist. The patient had a history of hypertension, hyperlipidemia, hypothyroidism and clinical depression. Four years prior to his visit to the internal medicine physician, the patient had been diagnosed with a calcified thoracic HNP. At that time, the treating neurosurgeon told the patient the thoracic disk could result in acute deterioration, including paraplegia and loss of bowel control. He also discussed the risks of surgery to correct the problem. The neurosurgeon urged the patient to seek another opinion, and if he elected to do nothing, to return for a follow up visit in a few months. The patient never returned to the neurosurgeon or sought further treatment for his back.

### Physician action

At the time of the first visit with the internal medicine physician, the patient's medical problems were reviewed. The physician's records for the patient included the prior CT findings from the neurosurgeon. A routine physical exam was performed and neurological findings were normal. The physician saw the patient routinely over the next 18 months. During these visits, there were no complaints of back pain.

Approximately seven months after his last visit, the patient returned to the internal medicine physician with diffuse low back pain. The neurological exam was normal; there was positive straight leg raising and no

change in bladder or bowel function. The patient also had good range of motion. It was noted the patient had a positive calcified disc in his back, as indicated by the previous studies. The physician told the patient to stay off his feet and not to lift anything. He prescribed Naprosyn and told the patient to return in one to two weeks if he was not better.

The patient also sought treatment from a chiropractor for his back pain. The records from the chiropractor were unclear, but it did not appear that any adjustments were performed. The chiropractor did give the patient a prescription and told him to apply ice.

Fifteen days after presenting to the internal medicine physician with back pain, the patient returned. He was admitted into the hospital for worsening right low back pain radiating to the right heel, now associated with urinary retention. Ataxia was noted. The internal medicine physician called in an orthopedic surgeon to consult. The surgeon conducted a thorough neurological exam in the presence of the internal medicine physician. All findings were normal. After the exam, the surgeon ordered a lumbar view MRI to be completed ASAP.

The following day, the patient was again seen by the orthopedic surgeon. The patient reported that his back was better and there were no neurological symptoms. The patient was also seen by a urologist, at the request of the internal medicine physician. The IM physician suspected a neurogenic etiology for the urinary retention.

The urologist noted there was no previous, significant history of urological problems, and the patient reported no problems with his urinary bladder despite the acute back pain he experienced four years previously. The examination revealed normal sensation throughout the perineum, a normal bulbocavernosa reflex, tight anal sphincter tone and normal anal wink. The urologist concluded the urinary retention was caused by the acute back pain and accentuated by narcotic medications. In addition, the anticholinergic effects of antidepressants were thought to be

playing a role. He felt the patient would recover and intermittent catheterization was ordered. The urologist did not believe the bladder dysfunction was neurological in origin.

Early the next morning, the internal medicine physician and the orthopedic surgeon were called to the hospital by the nurses. The nursing entry indicates the patient was experiencing a lack of sensation from the waist down and an inability to move the lower extremities with loss of reflexes. According to the orthopedic surgeon's note, the patient had severe back spasms at 2 p.m. the previous afternoon. The MRI ordered ASAP by the surgeon the previous morning had not yet been performed. Another MRI was ordered stat, and revealed an extremely large herniated nucleus pulposus at T8-9 level causing severe cord compression.

The patient was transported to another hospital for an emergency thoracotomy with anterior discectomy of T8-9. The procedure was performed without complication. The patient regained partial motor and sensory function in the left leg. He was discharged and transferred to a local rehabilitation hospital. After leaving the rehab hospital, the patient continued physical therapy for approximately two years. At present, the patient can walk with a cane, but suffers permanent loss of bowel and bladder control.

### Allegations

The main allegations in this case were:

- failure to conduct a proper and adequate neurological exam (both physicians)
- failure to conduct a rectal and perineal exam (both physicians)
- failure to refer patient to a competent orthopedic surgeon (IM)
- failure to obtain an emergent MRI scan (both physicians)
- delay in performance of surgery (surgeon)
- failure to obtain more experienced and qualified consultants (both physicians)

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The Reporter will feature a bimonthly column to answer your most frequently asked questions about asset protection. We invite you to email or write Ken Vanway with your questions, [ken@vanway.org](mailto:ken@vanway.org) or Law Office of Ken H. Vanway, P.C., First Commercial Bank, 1110 RR 620 South, Suite B, Austin, Texas 78734.

The information provided in this article is not to be construed as legal advice and should not be relied upon without specific consultation with a professional.

Common mistakes with physicians and the Texas Homestead Law

- Can you afford to sell your home?

Example: Physician owns a 10,000 square foot, creditor-proof home worth \$2 million; physician's children are now grown and physician decides it is time to sell the home and downsize. The problem is that there is a \$10 million malpractice judgment against physician. If physician sells the home and does not rollover 100 percent of the sales proceeds into a new home, then the excess sales proceeds are subject to creditors.

# Protecting your assets from lawsuits

By Ken H. Vanway, P.C., attorney at law



## About the author

Ken H. Vanway is board certified in Estate Planning and Probate Law — Texas Board of Legal Specialization. Ken has more than 20 years experience. His firm practices in many areas of estate planning and lawsuit protection including wills, living trusts, insurance trusts, family partnerships, charitable trusts, private foundations and asset protection. For more information, please visit his web site, [www.estateplanning.com/kenvanway](http://www.estateplanning.com/kenvanway).

Question: Are my house and household furnishings protected against a malpractice judgment?

Section 41.001 of the Texas Property Code (TPC) exempts your homestead from seizure from the claims of creditors with certain exceptions related to taxes, purchase money mortgage, home improvement work and the like.

A "homestead" in Texas is 10 acres if urban (single or married) or 100 acres if rural (200 acres for a married couple) regardless of value. Some states impose a maximum dollar value but Texas does not. The 10 acres for urban homesteads was increased from one acre effective January 1, 2000. Temporary renting of a homestead does not change its homestead protection. If you sell your homestead, the proceeds of sale are not subject to seizure for 6 months after the date of sale. Therefore, if you purchase another homestead and roll the proceeds into the new home, then the proceeds are protected. However, if you do not roll the sale proceeds into a new homestead within 6 months, then the proceeds may be lost to a judgment creditor.

In addition to the real property exemption, Section 42.001 TPC exempts certain qualified personal property not to exceed \$30,000 for a single adult (\$60,000 for a married couple). Qualified property reflects our agricultural history and includes home furnishings, food, wearing apparel, vehicles, jewelry (not to exceed 25 percent of the limit), two firearms, farming/ranching implements, tools, equipment, books used in trade or business, sporting equipment including bicycles, household pets, and two horses, 12 head of cattle, 60 head of other livestock and 120 fowl.

Moral: It is difficult to get your equity out of a home if you need it in the future. Don't put all of your eggs in this one basket.

- Be careful on financial statements

When you are sued, one of the favorite deposition questions asks you to list all individuals or institutions to whom you have provided a financial statement in the past 6 years. All of us routinely provide financial statements to the bank, the mortgage company, financial planner, etc. Clients will unknowingly list their vehicles, household furnishings and jewelry at inflated values far in excess of the \$30,000/\$60,000 personal property exemption even though the lender is not going to lend money based upon these assets. This piece of evidence can give cause allowing the plaintiff's attorney to spend days going through the house room-by-room, utensil-by-utensil until you will gladly pay them to go away.

Moral: 1. Never list personal property on your financial statement. 2. If you have important antiques, carpets, paintings, artwork, etc., then create a separate entity to own these valuable collectibles and lease the use of them.

TMAIT will be offering physicians a number of opportunities to attend asset protection seminars in 2002. Watch for information about a seminar near you in your TMA publications and on the TMAIT web site, [www.tma.org](http://www.tma.org).

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## closed claim study continued

### Legal implications

Overall, TMLT consultants were supportive of the care rendered in this case. When he saw the patient's condition, the internal medicine physician immediately admitted him to the hospital and called in orthopedic and urology consults. The orthopedic surgeon's evaluation of the patient was consistent with a patient who had long-standing low back problems from pre-existing conditions that were not emergent in nature.

However, both plaintiff and defense experts were critical of the internal medicine physician's failure to advise both the orthopedic surgeon and the urologist of the patient's prior diagnosis of calcified thoracic HNP. It was alleged that the internal medicine physician's failure to do so led the subsequent consultants to the wrong conclusion.

The orthopedic surgeon was also criticized for not ordering a stat thoracic MRI at the time the patient was admitted. The orthopedic surgeon testified that he did not see the need for a stat MRI because the patient had a normal neurological exam. There also was some question as to whether or not a thoracic MRI

at the time of admission would have shown a surgical lesion.

### Disposition

This case was settled for \$150,000 on behalf of the internal medicine physician and \$150,000 on behalf of the orthopedic surgeon.

### Risk management considerations

**1. Communication between providers** — Sharing a patient's past medical history with subsequent treating physicians and consultants is essential. Relevant past history must be communicated in the medical record and, where appropriate, communicated directly to the consulting physician.

In this case, the internal medicine physician failed to relay relevant past medical history (prior diagnosis of calcified nucleus pulposus) to the orthopedic surgeon which may have affected the surgeon's assessment of the urgency in obtaining an MRI. However, the orthopedic surgeon cannot completely rely on information given by a referring physician and must perform his own history and physical examination.

**2. Inpatient tests** — The physician ordering diagnostic testing in a hospital setting should be judicious in acknowledging priority with regard to time for completion and appropriate follow-up of the results. Physicians may dangerously assume that a hospitalized patient will undergo ordered tests in a timely manner due to round the clock monitoring. Test orders must be clear as to their urgency, i.e., routine, STAT, etc. Unless it has a specific meaning in your institution(s), ASAP is too vague a time frame. It may also be necessary for the ordering physician to advise appropriate hospital personnel of the nature of the patient condition and why the test is to be performed. Lastly, the ordering physician must follow-up on the completion of tests ordered.

In this case, there was a question as to whether the delay in performance of the MRI resulted in the patient's adverse outcome, since it may or may not have shown a surgical lesion at the time of admission. Timely performance of the MRI may have helped to demonstrate the physicians could not have prevented the patient's paralysis.