

## Emergency Patients: Obligation To Treat And Effective Consent

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The focus of this article is twofold. First, we will examine and discuss the legal obligation to treat patients who present themselves for treatment via emergency rooms. Secondly, we will examine the issue of legally valid consent to medical treatment in the state of Texas. We all know the basic rule about patients who present themselves for emergency treatment. Simply put, we must treat the patient. But under what laws does this obligation arise and at what point has a provider met its obligation to treat? As one might expect, there are both federal and state laws which impose the obligation to treat.

At the federal level, we have the Emergency Medical Treatment and Active Labor Act, popularly known by its acronym, "EMTALA". EMTALA imposes the obligation to provide for examination and treatment for emergency medical conditions and women in labor. The first requirement is that of "medical screening". The law requires that, in the case of a hospital that has an emergency room department, if any individual presents himself to the emergency department and a request is made on the individual's behalf for examination or treatment for a medical condition, the hospital must provide for an appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition exists. The obligation to examine and/or treat does not depend on whether the patient is eligible for Medicare or Medicaid benefits. The term "emergency medical condition" means:

- A.1.** a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in;
- 2.** placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious

jeopardy;

**3.** serious impairment to bodily functions; or,

**4.** serious dysfunction of any bodily organ or part; or,

(B) with respect to a pregnant woman who is having contractions;

**1.** that there is inadequate time to effect a safe transfer to another hospital before delivery; or,

**2.** that transfer may impose a threat to the health or safety of the woman and unborn child.

EMTALA also imposes an obligation to stabilize a patient within the operational and clinical capabilities of the facility, or transfer a patient to another appropriate facility. A hospital may not transfer a patient that presents with an emergency medical condition until the patient is stabilized. Until the patient has been stabilized, no transfer should occur unless the following occurs:

(A)(i) the individual (or a legally responsible person acting on the individual's behalf) after being informed of the hospital's obligations under the law and of the risk of transfer, in writing requests transfer to another medical facility;

(ii) a physician signs a certification that based on the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual and, in the case of labor, to the unborn child from effecting the transfer, or,

(iii) if a physician is not physically present in the emergency department at the time the individual is transferred, a qualified medical person (which can in certain cases be a nurse), after a physician in consultation with the qualified medical person, has made the determination and the physician subsequently countersigns the certification that transfer is appropriate.

A hospital which negligently violates the provisions of EMTALA is subject to a civil money penalty of not more than \$50,000.00 (or not more than \$25,000.00 in the case of a hospital with less than 100 beds) for each violation. Multiple

violations can be cited in connection with a single emergency patient encounter. An individual may also bring a civil claim for negligence in the provision of emergency services under EMTALA, as well as state law negligence and malpractice claims. The statute of limitations for initiating such legal action by an individual is two years from the date of the alleged violation.

Finally, one should note that EMTALA has non-discrimination provisions, which make it illegal to discriminate against any individual seeking emergency treatment on the basis of their health insurance status or other factors affecting their inability to pay. The Texas Health & Safety Code has similar provisions and definitions. Rather than describing and discussing those provisions of Texas law at this time, which mirror the federal law, if any readers have questions specific to Texas law on emergency care, feel welcome to contact the writer of this article for any additional information required. At this point, let us turn now to the issue of consent to treatment.

In almost all scenarios involving an individual seeking emergency care, there is no issue of refusal of consent to treatment. Of course, if we do not address this issue, it will no doubt arise. For purposes of EMTALA, a hospital is deemed to have met the requirement of providing examination and treatment if the hospital offers examination and treatment and informs the individual (or a person acting on the individual's behalf) of the risks and benefits to the individual of such examination and treatment. Where the individual refuses treatment, hospital personnel shall take all reasonable steps to secure written informed consent of the individual's refusal to accept examination and/or treatment. The laws in Texas pertaining to consent to medical treatment are found within the Texas Health and Safety Code and also within certain portions of the Texas Family Code. The Consent to Medical Treatment Act is found at Section 313.001 of the Texas Health and Safety Code. This act defines an adult as a person "18 years of age or older, or a person who has had the disabilities of minority removed". The act also contains some other definitions of importance, such as "decision-making

capacity", which means an ability to understand and appreciate the nature and consequences of a decision regarding medical treatment and the ability to reach an informed decision. The term "incapacitated" is also defined within this act as "lacking the ability, based on reasonable medical judgment, to understand and appreciate the nature and consequences of a treatment decision...". Where the patient lacks decision-making capacity, or is incapacitated, the hospital must look to a "surrogate decision-maker", which is defined by the act as "an individual with decision-making capacity who is identified as the person who has authority to consent to medical treatment on behalf of an incapacitated patient in need of medical treatment". We all know that our respective hospital administrations, risk managers and attorneys have provided the admissions, clinical and nursing staff with "Consents of Admission" or "Consent to Treat" forms, which are usually signed by patients or a parent at admission and this is not a problem. But what about the scenario where it is unclear whether the patient has the requisite mental capacity to give informed consent to treatment, or there is an issue about whether the patient can be treated at all because they appear to be a minor? Here are some answers and guidance on those questions.

If an adult patient in a hospital (or in a nursing home) is comatose, incapacitated, or otherwise mentally or physically incapable of communication, an adult surrogate, who has decision-making authority and is willing to consent to medical treatment on behalf of the patient may give legally effective consent to treatment, however, the law states an order of priority for such "surrogate" consent. The order of priority for obtaining consent to treat from one acting on the patient's behalf is as follows:

(1) the patient's spouse; (2) an adult child of the patient who has the waiver and consent of all other qualified adult children of the patient to act as the sole decision-maker; (3) a majority of the patient's reasonably available adult children; (4) the patient's parents; or (5) the individual clearly identified to act for the patient before the patient became incapacitated, the patient's nearest living relative, or a member of the clergy. Any dispute about who has the right to act as a surrogate decision maker may be resolved only by a court of appropriate jurisdiction under Chapter V of the Texas Probate Code. A surrogate

decision-maker may not consent to: (1) voluntary inpatient mental health services; (2) electro-convulsive treatment; or, (3) the appointment of another surrogate decision-maker

"Fine", you say, but what if the patient is all by himself or herself and it appears that the patient is a minor accompanied only by a "friend" ,who also appears to be a minor? How do we deal with that? Again, Texas law provides a checklist of sorts which addresses this issue. It is contained within the Texas Family Code and specifically addresses consent to treat for minors. A child may consent to medical, dental, psychological and surgical treatment to be provided by a licensed physician or dentist if the child:

(1) is on active duty with the armed services of the United States;

(2) is 16 or older and resides separate and apart from the child's parents, managing conservator, or guardian and regardless of the duration of the residence; and the child is managing their own financial affairs, regardless of the source of income;

(3) consents to the diagnosis and treatment of an infectious, contagious or communicable disease that the provider is required to report to the Texas Dept. of Health;

(4) is unmarried and pregnant and consents to hospital, medical or surgical treatment, other than abortion, related to the pregnancy;

(5) consents to treatment for drug or chemical addiction and/or dependency;

(6) is unmarried and has actual custody of their own biological child and consents to medical, dental, psychological or surgical care for their child.

Consent to treat given by a minor in conformance within these guidelines and priorities, as set forth by Texas law, is not subject to disaffirmance, i.e., revocation, because of minority. It should be pointed out, however, that hospital personnel's efforts in following the steps provided in the Texas Health and Safety

Code and the Texas Family Code, as it pertains to consent by minors, should be clearly documented within its records. For liability reasons, this is especially important in instances of emergency patients that arrive and then refuse treatment, as well as those patients who require a transfer to another facility for appropriate treatment.

Finally, the laws on informed consent to treatment do not always address every situation every time. There are situations which will arise from time to time where the answer does not readily appear from reading the law. In such situations, the prudent course of action, in my humble opinion, is to render the appropriate examination and treatment (unless it is refused), whilst simultaneously contacting your respective risk management director, or other senior member of the administration who can direct the appropriate resources to handle the issue.