



Georgia Society for  
Healthcare Risk Management

# GSHRM GAZETTE

## THE CORONER – TO CALL OR NOT TO CALL

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The other day I was discussing with an administrator of a skilled nursing facility the subject matter of an in-service that she recently arranged for her nursing staff at the nursing home. She told me that she was having the county coroner give a talk to inform staff on the issues of when a coroner should be called, what to do in the event the coroner is called and the duties of the coroner once they arrive at the scene. Although I thought to myself, "Wow...I bet you that had them on the edge of their seats for that one!" I, instead, complimented her on expanding her choices of in-service possibilities. You see, from my experience it was very rare for a coroner to be called to a death which occurred in a nursing home. I should day for the last 10 years or so it has been rare and, prior to that, I would have to say that the only times I heard the title of coroner mentioned was usually related to the following lawyer joke (said to have come from an actual hearing) which was prevalent at that time:

A defendant's attorney was cross examining a coroner. The attorney asked, "Before you signed the death certificate had you taken

the man's pulse?"

"No," the coroner replied.

The attorney then asked with a bit of sarcasm, "Did you listen for a heart beat?"

The coroner said, "No."

"Did you even check for breathing?" asked the attorney with totally incredulity.

Again the coroner replied, "No."

The attorney, feeling as if the coup de grace was at hand, asked, "So, when you signed the death certificate you had not taken any steps to make sure the man was dead, had you?"

The coroner, now tired of the brow beating said, "Well, let me put it this way. The man's brain was sitting in a jar on my desk, but for all I know he could be out there practicing law somewhere."

I still chuckle at this story even though it does disparage my brothers and sisters of the Bar.

The administrator began telling me how incredibly informative the in-service was

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for her nursing staff and how much the nurses enjoyed the coroner.

This, of course, intrigued me so I began doing some research on my own.

The first question I had to ask was: What does the coroner do? I would venture a guess that many persons, even though the coroner is an elected office, would not know the answer to this question. The coroner is charged, in certain circumstances:

1. To determine cause of death
2. When called to a scene, to inventory and take possession of personal belongings of the deceased if the next of kin is unavailable
3. To pronounce death

Armed with this information, I began to research what exactly is involved in each of these charges of the coroner.

### **Cause of Death**

Under the law, when any person dies in any county in Georgia as a result of violence; by suicide or casualty; suddenly when in apparent good health; when unattended by a physician; in any suspicious or unusual manner, with particular attention to those persons 16 years of age and under; after having been admitted to a hospital in an unconscious state and without regaining consciousness within 24 hours of admission the coroner must be called.” The law provides that the “when unattended by a physician” does not apply to a person who is a patient of hospice. O.C.G.A. 45-16-24. Therefore, the question is: What about

when someone dies in a skilled nursing facility? The two most frequent areas which will mandate a call to the coroner for deaths within a nursing home are: (1) as a result of casualty, and (2) when unattended by a physician. As a result of casualty (or trauma) could be a fall, a reaction to medication, a death that occurs during an elopement or asphyxiation from entanglement in side rails. Under the law "died unattended by a physician" means a death where a person dies of apparently natural causes and has no physician who can certify the death as being due to natural causes. If the suspected cause of death directly involves any trauma or complication of such trauma, the death must be reported to the coroner or county medical examiner. An unattended death also occurs when a person is admitted in an unresponsive state to a hospital and dies within 24 hours of admission.

Since the law which defines when the coroner must be called is drafted in the disjunctive, if a resident dies while in a nursing home and the resident is not under hospice care either (1) a doctor must physically appear at the nursing home to determine the cause of death, or (2) the coroner's office must be called. However, as we are dealing with the law, for every rule there must be an exception. In 2006, the Georgia Legislature created a law which allowed for a Physician's Assistant or Registered Professional Nurse who is employed by the nursing home to make the determination and pronouncement of



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death if the death occurred within a licensed nursing home even in the absence of a physician. However, if the resident is an organ donor or the resident died from other than natural causes, the physician must be called. O.C.G.A. 31-7-16.

This presents an issue for those of us who have worked in the nursing home environment. If a resident dies at 2 a.m., the resident's physician may not be willing to get up at 2 a.m. to determine and pronounce death. Now we have an unattended death where the coroner's office must be called under O.C.G.A. 45-16-24. However, in conversations with coroners from around the state, the problem, particularly in nursing homes, now becomes one of investigation. Once the coroner's office is called, the investigation of cause of death is initiated. The coroner, or their representative, must view the body and the evidence to determine cause of death. However, all too frequently, the coroner will arrive to discover that the resident has been bathed, the linens have been changed and the room tidied. The problem is that much of the physical evidence which may be of help in establishing cause of death has now been destroyed.

One coroner I spoke with gave an example where she was called to a nursing home after a resident expired. Apparently, the resident, who was on dialysis, had a prob-

lem with her shunt. The result was that the resident bled to death. By the time the coroner arrived at the nursing facility the resident had been bathed, linens bagged and the room sanitized. Of course, for the coroner, this translates into a problem with her investigation. For those of us in risk management or who daily dwell in the menagerie of litigation, you can already hear the plaintiff's attorney screaming at the top of his or her lungs about the spoliation and destruction of critical evidence. But of possible greater concern, particularly to those who participated in the cleaning up of the resident's room, are the possible criminal penalties. Although it is not widely known, pursuant to O.C.G.A. 45-16-47, it is a crime to fail to comply with the provisions of the Death Investigation Act.

### Inventory Belongings of Deceased

The coroner, in the absence of the next of kin of the deceased person, shall take possession of all property of value found on the deceased. The coroner must make an exact inventory of the items in his or her report, and then give the items to the person entitled to its custody or possession. The critical issue for the protection of the coroner and the facility is to ensure that this inventory sheet is completed and that it is witnessed. As we all know missing items is a taboo subject in most

nursing homes. However, a proper inventory that is witnessed may reduce the likelihood of spending hours upon hours searching for "missing items," filling out a grievance report, dealing with a state reportable and, heaven forbid, a complaint survey.

Also, the coroner or peace officer (the coroner is required to call a peace officer to the investigation) shall take possession of any objects, anatomical specimens, or articles which, in his or her opinion, may be helpful in establishing the cause of death, manner of death, or identification of the deceased.

### Pronouncement of Death

In limited circumstances the coroner can be called on to pronounce death. In the setting of a licensed nursing home, if a qualified physician or a registered professional nurse employed by the facility is not available, a coroner may make a pronouncement of death at the investigation scene if, and only if, one or more of the following conditions is met:

1. The body is in a state of rigor mortis with lividity present
2. The body is in a state of decomposition evidenced by a component of putrefaction
3. The body is skeletonized
4. Death has been established by qualified emergency medical services personnel

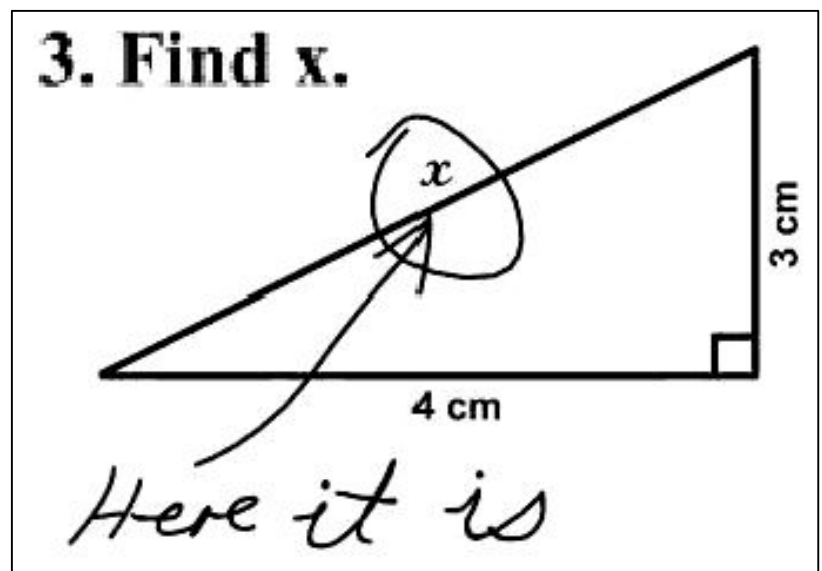
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### Into the Future

Given the speed at which the laws and regulations change in the area of health care these days, you probably have better odds in Las Vegas than accurately predicting what is likely to happen in the future. However, there is an interesting development in several states that deserves mentioning. Missouri and Arkansas recently enacted law which requires a nursing home to report all deaths to the coroner. Several states are looking at legislation to follow this lead. The argument for this legislation is that proper investigation should also apply to deaths within a nursing home but are frequently not reported because of a lack of oversight. The legislation seems to have good traction in these other states and I would anticipate many other states passing similar laws. At this point the one effective argument against this law is a financial one. As coroners are paid on a per case basis, this would significantly increase the budget required for coroners in each county. Given the present economy, legislators are hesitant to pass laws which increase budgets within state and county departments.

So...after all my research the one thing I certainly discovered. My administrator really did have a good idea when she invited the coroner to the nursing home for an in-service. My advice of calling the coroner is not a big surprise to those in risk management. Formulate a policy and procedure on when the coroner is to be called and ensure that the nurses are educated on the policy and procedure.





## **Restrictive Covenants Risky for Georgia Employers? Not Anymore...**

By: Jeffery L. Thompson, Managing Member, Constangy, Brooks and Smith, LLP

For those of you who were led to believe enforcing employment related restrictive covenants in Georgia was impossible – think again. Georgia has now joined the ranks of most other states and has passed legislation allowing courts to modify unreasonable restrictive covenants in employment in the interest of equity. These new changes apply to all forms of restrictive covenants in employment agreements including: non-disclosure of confidential information covenants, non-solicitation covenants, and non-competition covenants (also called “non-competes or noncompetition agreements”). Employment agreements containing restrictive covenants will reduce the risk of loss, primarily economic loss, should an executive or professional (for example, a doctor) leave employment and begin or join a competing business using confidential information to gain a competitive advantage or solicit patients and customers.

Non-disclosure of confidential information covenants are used to prohibit employees from disclosing information that has been kept confidential by the employer. Types of confidential information may include computer software, upcoming products or services, client’s lists, patient lists, marketing plans, strategy, financial information, internal procedures and protocols, etc. In the medical setting, these agreements are

commonly used to prohibit business executives from taking marketing strategies and financial information to use during employment with another employer. These covenants are also used to prevent doctors from taking patient lists, patient medical information, pricing information, and projected profits and losses for use with another employer or in his/her own private practice.

Non-solicitation covenants are used to restrain an employee, for a stated period of time following termination, from soliciting or attempting to solicit, directly or by assisting others, any business from the employer’s patients or customers. This includes actively seeking prospective patients or customers with whom the employee had material contact during his or her employment for purposes of providing products or services that are competitive with those provided by the employer. In the medical field, these agreements are used by hospitals and doctor’s practice groups to restrict individual doctors from soliciting their patients when the doctor makes the decision to leave and start a competing medical practice or begin employment with another competing medical practice group or hospital. Oftentimes, these covenants are also used to prohibit former employees from soliciting other employees away from the hospital or medical practice group.

Non-competition covenants are the most popular restrictive covenants and are used to prohibit employees (current or former) from entering into a similar trade or profession in competition with the same business as the employer. These covenants are commonly utilized by employers in the medical field to restrict the activities of doctors beginning or transferring to competing practice groups or hospitals.

### **History**

Traditionally, restrictive covenants in employment agreements have been disfavored in Georgia and have only been upheld under the narrowest of conditions. The enforceability of restrictive covenants depended largely upon their strict compliance with complex rules developed by Georgia courts. Quite often, Georgia courts rejected restrictive covenants whose time duration was more than two years, included more than a limited, specific geographic area, or included restrictions on trade with persons who were not the employee’s customers at the time of termination or who are not directly in competition for the same specialized services that the employee previously provided to the former employer. Furthermore, Georgia courts were not allowed to “blue pencil” (i.e., modify) restrictive covenants to make them enforceable.

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### Overview of Georgia's Restrictive Covenants Act

As a result of legislation in 2009, a constitutional amendment ratified by Georgia voters on November 2, 2010 and arguably effective on January 1, 2011, and finally, a bill signed by Governor Deal on May 11, 2011, Georgia courts are now allowed to modify restrictive covenants in employment agreements. In addition to changing Georgia's public policy on restrictive covenants, this law provides a framework for drafters of restrictive covenants. The down side is that legal practitioners and courts continue to struggle with the effective date of the new Georgia Restrictive Covenant Act. However, the following is clear: 1) Any restrictive covenants agreements entered into before November 3, 2010, are subject to old the Georgia restrictive covenants law; 2) Any agreements entered into after May 11, 2011, are subject to the new Georgia restrictive covenants rule; and 3) Any agreements entered into on or after November 3, 2010 through May 11, 2011 are subject to interpretations as to which law applies. Regardless of the applicable effective date, the new legislation overturns previous hostile and unforgiving rules previously applied, and adopts a flexible approach to determine the enforceability of restrictive covenants. In so doing, the legislation provides presumptions favoring restrictive covenants in the employment setting that meet certain

standards and permits courts to modify agreements to be enforceable when necessary.

### New Framework for Drafting Restrictive Covenants

In addition to the Georgia courts now being able to modify restrictive covenants in employment agreements, the law also provides parameters for restrictive covenants.<sup>1</sup>

#### Non-Disclosure of Confidential Information Covenants

The new legislation eliminates any time limit requirement for covenants restricting the use and disclosure of confidential information, therefore, confidential information may be protected as long as it continues to have value and remains confidential.<sup>2</sup>

Another significant change under the new law is that a definition of confidential information is provided. Under the old law, the contract defined what the employer believed was confidential information. Additionally, the law also defined what information is not confidential. Confidential information is defined as data and information: (1) relating to the business of the employer, regardless of whether the data or information constitutes a trade secret as that term is defined in Code Section 10-1-761; (2) disclosed to

the employee or of which the employee became aware of as a consequence of the employee's relationship with the employer; (3) having value to the employer; (4) not generally known to competitors of the employer; and (5) which includes trade secrets, methods of operation, names of customers, price lists, financial information and projections, route books, personnel data, and similar information.<sup>3</sup> This is a significant change from the old law in which confidential information had to be specifically defined.

The new law further states confidential information is not data or information: (1) which has been voluntarily disclosed to the public by the employer, except where such public disclosure has been made by the employee without authorization from the employer; (2) which has been independently developed and disclosed by others; or (3) which has otherwise entered the public domain through lawful means.<sup>4</sup> Therefore, when drafting non-disclosure of confidential information covenants, employers must keep in mind the type of information they are protecting and how the information is kept confidential and valuable.

#### Non-Solicitation Covenants

The new law states that non-solicitation covenants do not have

<sup>1</sup> O.C.G.A. §§ 13-8-51 (11-12), 13-8-53(d), and 13-8-54(b).

<sup>2</sup> O.C.G.A. §13-8-51(9).

<sup>3</sup> O.C.G.A. §13-8-51(3)

<sup>4</sup> *Id.*

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to provide a reference to geographic area or the types of products or services considered to be competitive to be enforceable. The statute proposes the following language in the absence of a geographic restriction: "soliciting or attempting to solicit business from customers" is adequate.<sup>5</sup> Such a statement will be narrowly construed to apply only to: (1) the employer's customers, including actively sought prospective customers, with whom the employee had material contact; and (2) products or services that are competitive with those provided by the employer's business.<sup>6</sup> Therefore, if no geographic restriction is included, the above language should be used.

### Non-Competition Covenants

The new law provides a clear road map for the long-standing restrictions of time, geography and scope in non-competition covenants. The new law states that a time limit of two years or less is presumed reasonable, while non-compete covenants of more than two years are presumed unreasonable.<sup>7</sup> The new law further states that a geographic territory which includes the areas where the employer does business at any time during the parties' relationship, even if not known at the time of entry into the restrictive covenant, is reasonable pro-

vided that: (1) the total distance encompassed by the covenant is also reasonable; (2) the agreement contains a list of particular competitors as prohibited employers for a limited period of time after the term of employment or a business or commercial relationship; or (3) both subparagraphs (1) and (2) of this paragraph.<sup>8</sup> The new law suggests the following language in regards to employment restricting scope and time "of the type conducted, authorized, offered, or provided within two years prior to termination" or similar language containing the same or a lesser time period. The phrase "the territory where the employee is working at the time of termination" or similar language will be considered a sufficient description of geographic areas if the person or entity bound by the restraint can reasonably determine the maximum reasonable scope of the restraint at the time of termination.<sup>9</sup>

However, the law does limit the types of employees who can enter into agreements with non-competition covenants. Those types of employees include those who in the course of employment:

1. Customarily and regularly solicit for the employer customers or prospective customers
2. Customarily and regularly engage in making sales or obtaining orders or contracts for

products or services to be performed by others

3. Perform the following duties:
  - A. Have a primary duty of managing the enterprise in which the employee is employed or of a customarily recognized department or subdivision thereof
  - B. customarily and regularly direct the work of two or more other employees; and
  - C. Have the authority to hire or fire other employees or have particular weight given to suggestions and recommendations as to the hiring, firing, advancement, promotion, or any other change of status of other employees; or
4. Perform the duties of a key employee or of a professional.<sup>10</sup>

Therefore, if the employee's job duties do not fall into one of the above descriptions, a non-competition covenant should not be entered into and will not be enforced by the courts. However, this is an extensive list and will include salesmen, CEO's, CFO's, department heads, doctors, and other professionals.

The scope of competition restricted is measured by the business of the employer. The new

<sup>5</sup> O.C.G.A. §13-8-53(b).

<sup>6</sup> *Id.*

<sup>7</sup> O.C.G.A. §13-8-57.

<sup>8</sup> O.C.G.A. §13-8-56(a-c).

<sup>9</sup> O.C.G.A. 13-58-53.

<sup>10</sup> O.C.G.A. §13-8-53(a)(1-4).



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law does not address in detail the restrictions on the scope of the agreements or provide sample language, but so long as the restriction covers activities the employee was engaged in while employed, the scope requirement should pass judicial scrutiny.

While it is certainly suggested that non-competition covenants that operate during employment still contain restrictions on time, geography, and scope, there is a safe harbor for employers whose agreements are deficient. So long as the restriction promotes or protects the subject matter of the agreement or deters a conflict of interest, it will be deemed reasonable. Importantly, this safe harbor does not apply to non-competition covenants that govern post termination non-competition.<sup>11</sup>

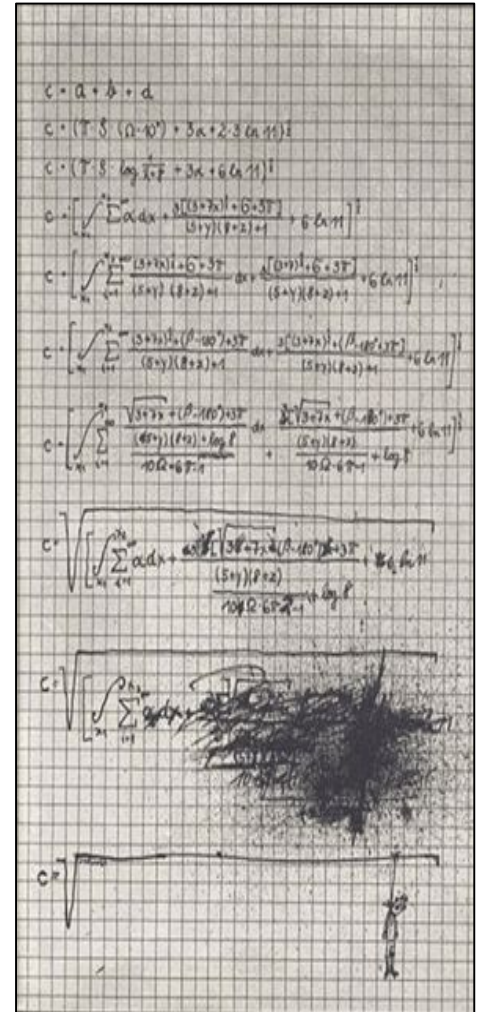
### Conclusion

This is a new area of the law that has not yet been fully explored to its fullest. Even now, arguably six months to a year after ratification, there is no guidance from Georgia courts as to how or to what extent, they will modify restrictive covenants. At this point, it is simply too early to tell how courts will handle their new found ability of modification.

Practically speaking, as the healthcare industry expands, hos-

pitals, independent medical practitioners, and physicians' offices will seek to have specialized individuals bound by non-competition covenants, non-solicitation covenants, and non-disclosure of confidential information covenants as competition in the field expands – not only with expertise of the physicians, but also, with other types of medical professionals and medical sales professionals. These agreements will also restrict solicitation by individuals who leave employment and attempt employee raids on previous employers. One caveat, courts may consider the economic hardship imposed upon an employee by enforcement of the covenant.<sup>12</sup> This may be an important consideration in drafting restrictive covenants in small towns or rural areas with limited medical providers or facilities – courts may be less willing to enforce unreasonable or over broad covenants if patient access to healthcare is already limited.

In conclusion, it is important for all Georgia employers to re-draft all employment agreements containing restrictive covenants to take advantage of this new law. The benefits certainly outweigh the risks. Until there is a case with restrictive covenants entered into after the effective date of the new law, Georgia courts will continue to apply the old rules, which are not employer friendly.



<sup>11</sup> O.C.G.A. §13-8-56(4).

<sup>12</sup> O.C.G.A. §13-8-58.

## Significant Case Decisions Regarding the Emergency Medical Treatment and Active Labor Act 2009 Updates

By: Ann Lambrecht, RN, JD, FASHRM, Vice President Risk Services, McNeary, Inc

In 2009, the Centers for Medicare & Medicaid Services refined the Emergency Medical Treatment and Active Labor Act (EMTALA) and clarified the obligations of Medicare-participating hospitals. Since the updates, we have closely followed court decisions of significant cases to determine their impact on our hospital clients and to assist us in providing guidance to them. This article will analyze the holdings of those cases and offer risk management recommendations in light of them.

### *Vasquez Rivera v. Hospital Episcopal San Lucas, No. CV 08-2223 (D.P.R. May 25, 2009)*

A pregnant patient presented to the Emergency Department with vaginal bleeding and pain, miscarried and underwent a dilation and curettage (D&C). When her symptoms persisted an examination revealed that a portion of the placenta was still intact. She had a second D&C and subsequently developed an infection that rendered her infertile.

She sued under EMTALA for failure to screen and stabilize. The court held that an outcome in a case does not necessarily support the sufficiency of the screening and that her admission equated to stabilization. Furthermore, the court found that the negligent performance of the

D&C did not constitute an EMTALA claim.

#### Comment:

This case was decided very close in time to the 2009 updates, making their impact difficult to determine. As to the screening issue, this is a reasonable holding because the patient was admitted for further screening and stabilization. Future courts may look differently upon whether a patient who has been admitted is still subject to EMTALA obligations. This is currently under evaluation with a decision anticipated before the end of the year.

### *Moses v Providence Hospital and Medical Center, 561 F.3d 573 (6<sup>th</sup> Cir July 17, 2009)*

A man was admitted through the Emergency Department, diagnosed with atypical psychosis and treated as an inpatient for 6 days. Ten days post-discharge, he murdered his wife.

The trial court granted the defendant summary judgment on the basis that EMTALA did not apply to an inpatient. The appellate court reversed the decision and held that the hospital's obligation to stabilize did not end with admission. The US Supreme Court denied review of this case.

#### Comment:

This is a very troublesome ruling considering the hospital provided inpatient stabilizing treatment. The court did not follow the reasoning of *Vasquez*. Instead, it noted a discrepancy between the treating physicians' progress notes over the patient's appropriateness for discharge and a reference to whether the patient's insurance would cover a longer stay. More concerning is the Supreme Court's refusal to grant review. This decision emphasizes the need for clear and consistent documentation among providers.

### *Ramonas v West Virginia Hospital-East, Civil Action No. 3:08-CV-136 (N.D. W. Va. October 13, 2009)*

A man presented to the Emergency Department with injuries sustained in a motor vehicle accident. He was told the X-rays were negative and was discharged home with pain medication for his muscle spasms. He was subsequently admitted for treatment of multiple fractures and a kidney injury.

He filed suit under EMTALA alleging disparate and therefore inadequate screening. The court dismissed the case and ruled he failed to demonstrate that his screening was disparate.

## Significant Case Decisions Regarding the Emergency Medical Treatment and Active Labor Act 2009 Updates

### Comment:

This holding is somewhat surprising when we consider that the plaintiff was subsequently found to have injuries that should have easily been identified by X-ray. Although, it does support the tenet that the outcome does not necessarily support the adequacy of the screening and stabilization.

### ***Abney v. University Medical Center of Southern Nevada, No.2:09 cv 02418-RLH-PAL (April 8, 2010)***

A pregnant patient presented to the Emergency Department with extreme pain and cramping. She and her fiancé claimed they were “berated, belittled and embarrassed” by staff during their five-hour wait to be seen. Frustrated by the long wait, they went to another facility where she was told she would not receive care any sooner. She went home where paramedics delivered a live infant. The baby was transferred to the first hospital where the Plaintiff sought care and died shortly after birth. A nurse advised the couple that the child was pre-viable however, the coroner’s autopsy revealed otherwise.

She filed suit under EMTALA alleging disparate and therefore improper screening and stabilizing treatment and a motion to disallow the state law’s damages cap on the EMTALA claim. The court upheld the disparate screen-

ing claim and ruled that the damage cap applied solely to that portion of the EMTALA claim.

### Comment:

The court’s decision was undoubtedly influenced by the unfortunate facts of this case coupled with the underlying public policy reason that EMTALA was originally enacted to prevent just this type of scenario. The lesson for us is to reinforce that screening and stabilizing treatment are ongoing events that should follow our practice guidelines.

### ***Morin v Eastern Maine Medical Center, No.CV-09-258 B-W (D, Me. July 28, 2010)***

A pregnant patient presented to the Emergency Department in pain and having contractions. When the ultrasound revealed her fetus was dead, she was advised to deliver at home and dispose of the fetus. She did as instructed and delivered a dead fetus.

She filed suit under EMTALA for inadequate screening and stabilization. The court ruled that EMTALA applied because the woman was considered to be in labor (notwithstanding the fact the fetus was non-viable) because she was not certified to be in false labor. Her primary care doctor had previously advised her that she was at risk for uterine rupture due to having had a Cesarean section. The court allowed the case

to go to the jury to determine the possible damage she may have sustained due to the discharge.

### Comment:

The facts of this case, even if exaggerated, are offensive and egregious. It is important to reinforce with medical staff that the viability of a fetus does not dictate the treatment. The fact that must be documented is whether or not the woman is in labor. If she is, stabilization must occur that includes delivery of the placenta. If not, she must be certified as being in false labor.

### ***Ramos-Cruz v Centro Medico Del Turabo, 3:2008 cv 01924 (April, 8 2011)***

A man presented to the hospital with abdominal pain, anemia and vomiting blood. He was diagnosed with gastrointestinal bleeding. Because there was no gastroenterologist on staff, he was transferred to another hospital for these services. He died within 2 days of treatment.

The family sued under EMTALA alleging an inappropriate transfer. The lower court found that the patient received appropriate pre-transfer treatment and was properly certified for transfer to a facility that provided services not available at the transferring hospital.

## Significant Case Decisions Regarding the Emergency Medical Treatment and Active Labor Act 2009 Updates

### Comment:

This case was most likely decided upon the documentation of the pre-transfer care provided within the capacity of the hospital and the, albeit sketchy, certification documentation. The court opined that the certifying physician's entry of the word "gastroenterologist" was "merely a summary" of the explanation for transfer. This is a good example that pertinent documentation need not be lengthy. However, more detail is advisable for certification than provided here.

***Guzman-Ibague v Sunrise Hospital and Medical Center.***  
**Nos.2:10-cv-1228-PMP-GWF, 2:10-cv-1983-PMP-GWF (D. Nev. June 1, 2011)**

A man committed suicide in the hospital's Observation Unit while waiting over 12 hours for evaluation by the County's Mobile Crisis providers. He had come to the hospital twice in three days with complaints of depression and anxiety.

The family filed suit under EMTALA alleging inadequate screening. The court held that EMTALA limits a screening examination to one that is within the capability of the hospital. The court noted that the hospital did not have the capability to perform a mental health screening exam but closely monitored him and implemented suicide precautions.

### Comment:

With the current mental health crisis that often requires us to hold these patients in the hospital while awaiting evaluation, transfer or placement, we should all take some comfort in this holding. A key factor in this court's decision was most likely based upon the hospital's well-documented efforts to protect the patient within their capability. We should emphasize that thorough documentation is not only good clinical practice but may also protect us from claims of a regulatory violation.

***Estate of Caillet-Bois v. Hospital Espanol Auxilio Mutuo De Puerto Rico, Civil No. 09-1201 (JP) (D.P.R. June 9, 2011)***

A man presented to the hospital with chest pain 4 days post-emergency cardiac catheterization and angioplasty. He waited 2 hours to be seen by the Emergency Department physician, was admitted and died the following day.

The family filed suit under EMTALA alleging a failure to provide appropriate screening. The court agreed and noted that the hospital failed to follow its own chest pain protocol.

### Comment:

This patient was improperly triaged that resulted in a 2-hour

wait without intervention and his ultimate demise. Practice guidelines should be followed to the letter and documentation should be required for any variance from them.

***Christus Health Se. Tex. v. Keegan, No. 09-10-00480-CV (Tex. App. July 28, 2011)***

A man presented with pain at the site of the cardiac catheterization that was performed two days earlier at a neighboring hospital. The cardiologist who performed the procedure was contacted by the Emergency Services doctor and agreed to accept the patient via transfer. The nurse at the receiving hospital called the cardiologist three times to advise him of the patient's deterioration. The doctor did not come in to evaluate the patient who was transferred to intensive care where he died within 4 hours of arrival.

The plaintiff's family sued under EMTALA and offered the testimony of 3 experts who were critical of his care. The receiving hospital alleged that the experts' reports did not satisfy the local court rule requirements and sought dismissal of the case. The trial court denied the dismissal and the appellate court affirmed this decision.

### Comment:

This physician was not techni-

## Significant Case Decisions Regarding the Emergency Medical Treatment and Active Labor Act 2009 Updates

cally on-call. However, he accepted transfer of the patient and was contacted on 3 separate occasions with very concerning status reports and did not come in to evaluate the patient. The 2009 updates specifically state that, when requested, an on-call physician must come to evaluate the patient or send another provider. This holds true of a provider who accepts transfer of a patient as well.

### Additional Topics:

Some topics in the 2009 EMTALA updates have not been the subject of any cases but warrant some discussion.

### Transfers: §489.24(f)(2)

You will recall that hospitals with specialized services must accept a patient who requires them. However, receiving hospitals are not obligated to accept transfers of inpatients. Many hospitals do not distinguish observation patients versus inpatients in their documentation. For patients you intend to transfer and are holding in observation units, ensure that the documentation is clear about their status or a receiving hospital may legitimately refuse to accept the transfer.

### On-Call List: §489.24(j)(1)

The hospital is required to maintain an on-call list of doctors, not groups, that are on-call to treat patients after initial screening. In addition, the hospital must state the required on-call physician response time in minutes rather than use words such as timely or promptly. Response time refers to the time the physician physically comes to the hospital to evaluate the patient rather than the call back time.

This information was designed to shed light on the reasoning of the courts who have decided cases since the 2009 EMTALA updates. Their decisions do not always follow the holding of cases previously decided and at times directly conflict with them.

Information on topics not yet tested within the legal system should serve to reinforce the requirements under the updates. As always, you should consult with legal counsel for advice on any suspected EMTALA issues that arise.



## Patient Elopement from 1013

By: Roger S. Sumrall and Matthew F. Branch, Bendin Sumrall & Ladner, LLC

Any time a physician or medical provider is dealing with a “GA 1013 patient,” or any patient who has given indication that he might pose a threat of harm to himself or others, unique challenges arise. First and foremost is the immediacy with which a the provider must make a determination about the patient’s potential to be an imminent threat to himself or others. Of course, the limited amount of information immediately available about a patient can make this initial determination difficult. Second, the complicated legal framework surrounding this situation is unquestionably daunting. Specifically, a medical provider in this situation is presented with a conundrum: If one allows a dangerous patient to *leave* the facility, one might be liable for the harm the patient causes himself or others; but if one *keeps* a potentially dangerous patient against his will, one risks liability for false imprisonment. Then, of course, each patient’s condition is different and each medical facility faces different circumstances, with limited resources, and many other patients in need of treatment. The myriad of distinctive characteristics each medical provider possesses inevitably leaves each with unique advantages and disadvantages, and accordingly requires individualized considerations for the implementation of an effective policy to evaluate and treat such patients, to address potential patient elopement, and to respond when

elopement takes place. What follows is: A brief discussion of the law surrounding these issues, some illustrative hypotheticals, and some general policy recommendations.

### I. Summary of Georgia Law and Potential Liabilities

We begin with a brief discussion of the major relevant points of law.<sup>1</sup>

#### Statutes and Immunity

First, Georgia law provide the process for the admission and involuntary commitment of mentally ill patients that pose a sufficiently serious threat. (See O.C.G.A. § 37-3-1, *et seq.*, Articles 40-44 & 80-85). In order to involuntarily commit a person, the person must pose a specific level of risk, provided in the statute as the “inpatient” criteria: *That the patient poses a substantial risk of imminent harm to himself or others as manifested by recent overt acts or recent ex-*

*pressed threats of violence presenting a probability of physical injury to self or others; or so unable to care for own physical health and safety as to create an imminently life-endangering crisis.* If a patient meets this criteria, a medical provider can be liable for that patient’s actions after allowing the patient to leave. If the provider commits a patient that does *not* meet this criteria, or without following the proper process in doing so, it can also be liable.

The several statutes addressing the involuntary processes are lengthy, and far from user-friendly, but they do reward the doctor/provider who endeavors to follow their requirements. This is because the statute grants an eligible defendant<sup>2</sup> *immunity* from civil or criminal liability for all actions *in connection with the admission and discharge* of such patients, as long as the defendant

<sup>1</sup> A more detailed citation, discussion, and analysis of the expansive statutory and case law applicable to these issues would not fit within the confines of this article. Please contact the authors for a more in-depth survey of the relevant law. NOTE: There is an analogous statutory framework for the involuntary commitment of patients posing a danger due to intoxication or withdrawal addressed in much of the applicable case law. O.C.G.A. § 37-7-1, *et seq.*

<sup>2</sup>“Any physician, psychologist, peace officer, attorney, or health official, or any hospital official, agent, or other person employed by a private hospital, or at a facility operated by the State...” O.C.G.A. § 37-3-4.

## Patient Elopement from 1013

has acted in good faith compliance with the statute.<sup>3</sup> This means a medical care provider can greatly reduce its potential liability by setting up a thorough process for ensuring statutory compliance related to the admission and discharge portions of the statute.<sup>4</sup>

In addition to the patient-risk standard for involuntary commitment, the statutory framework also provides detailed requirements for: The GA 1013 physi-

cian's certification<sup>5</sup>, the examination, evaluation, detention, admission procedure and time limits, initiation of court proceedings, emergency admission of patients after court order, notice requirements, transfer of patients, and more. Georgia Courts have demanded strict adherence to the evaluation, certification, and time limit requirements found in these statutes, if a defendant hopes to avail itself of statutory immunity via summary judgment of a case.

### Potential Liability

There are two general types of claims which might arise if a potentially dangerous patient is allowed to leave a facility, or is otherwise not restrained, controlled, treated, and/or involuntarily committed:

1. **Malpractice:** If there is privity of contract, meaning if the patient in question is an actual patient of the doctor/hospital, rather than one who just presents to the hospital,

the "Brandvain"<sup>6</sup> standard applies for private hospitals. In short, this means that the physician/hospital has the general duty to exercise the requisite degree of skill and care as the patient may require, just as in a normal medical malpractice case. In defense of such a claim, the doctor/hospital may show that it did not breach the standard of care, or that regardless of any such breach, the injury the patient caused to himself or others was not a foreseeable result, or not a result actually *caused* by the breach.

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<sup>3</sup> Malpractice prior to discharge is not immunized. See Purcell et al., v. Breese et al., 250 Ga. App. 472 (2001) (Court of Appeals affirming denial of summary judgment on general negligence and med-mal claims where the doctor had authorized discharge of patient who later committed suicide without first meeting/talking with patient or reviewing the most recent entries in his record, despite a history of suicidal threats, drug use, and recent (psychotic) statements of voices in his head telling him bad things about himself, after the patient demanded release and his mother agreed).

<sup>4</sup> Importantly, this Statutory Immunity under O.C.G.A. § 37-3-4 extends only to the individual (physician, psychologist, peace officer, etc.), not to the hospital or mental health facility. Krachman v. Ridgeview Institute, Inc., 301 Ga. App. 361, 364 (2009). Further, when a hospital is sued under a respondeat superior theory of liability, the principal (hospital) cannot avail itself of the immunity defense. *Id.* at 364. However, for an employee who is found immune under the statute, then there can be no respondeat superior liability derived therefrom.

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<sup>5</sup> A The "GA 1013 Form" is filled out by a physician or other statutorily authorized mental health treatment individual to initiate the process by which a police officer takes the patient into custody to go forward with the involuntary commitment evaluation process.

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<sup>6</sup> Brandvain v. Ridgeview Institute, Inc. et al., 188 Ga. App. 106 (1988) (reversing j.n.o.v. in a suicide case at a hospital specializing in treatment of alcohol/drug abuse, where patient had previously attempted suicide and displayed "near toxic psychosis," and they had already begun the process of involuntary commitment under O.C.G.A. § 29-5-1 (incapacitated by drugs or alcohol) two days before his suicide, but did not supervise him). NOTE: As a young lawyer, your author attempted to convince the Brandvain Court of Appeals that a patient who commits suicide in a mental hospital is by definition guilty of contributory negligence, and therefore barred from recovery. The trial court was convinced, and threw out a verdict against the mental institution. The Court of Appeals, however, disagreed and reversed the trial court. This case provides the most commonly cited analysis for failure to supervise and control a patient who presents danger under the statute

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2. **Control-based Negligence:** If there is *no* doctor-patient relationship, then there can be no malpractice claim. In such a circumstance, a more generalized negligence is the type of legal claim available against a provider, for the harm caused by a patient to himself or others. Specifically, a doctor/medical provider can be liable for its failure to exercise control that was legally available, if such failure was unreasonable. Bradley Center, Inc. v. Wessner et al., 250 Ga. 199 (1982). This control-based claim is based on the physician's duty which arises out of his ability to control a dangerous patient, by way of initiating voluntary commitment under the statute, where the knowledge available to him calls for it. Thus, to succeed with this type of claim, the plaintiff must show two things:

1. **The Ability to Control:** Was the "Inpatient" criteria met under the statute, such that the individual could be legally committed?

Did a person with the ability to initiate involuntary commitment under the statute fail to do so?<sup>7</sup>

Were there additional means of control of the patient that the physician failed to utilize (supervision, restraints, security officer, peace officer?)

2. **Danger:** Did the physician know or should he have reasonably known of the danger to self or others? (met if "inpatient" criteria is present, based on the patients full file, and all recent interactions/ observations by the staff)

In addition, claims can arise from the restraint of the seemingly dangerous patient or from an insufficient procedure initiating involuntary commitment:

1. **False Imprisonment:** This claim is available to a person who has been intentionally and unlawfully deprived of his liberty. The 'deprivation' can be accomplished by a detention/confinement at the hands of the hospital staff, or at the hands of the police at the physician's request. Where a *valid process* for a patient's detention is followed, there can be no liability for false imprisonment, because such a process is not

"unlawful."<sup>8</sup>

2. **Battery:** The touching involved in the physical restraint of a patient, if it is in conjunction with an *unlawful* deprivation of liberty, can be the basis for a battery (unlawful touching) claim.

3. **Malicious Use of Process:** Where a *valid process* is used to accomplish the patient's detention, but it is done for malicious purposes, this is the available claim (since false imprisonment cannot arise out of valid process).<sup>9</sup>

### Hypothetical Scenarios

#### Hypothetical 1

A doctor with a private practice is treating a patient for a physical illness/ailment. To the doctor's knowledge, the patient does not have any significant history of mental illness, violence, or attempts/threats of suicide. However, toward the end of the pa-

<sup>8</sup> "[A]n action for false imprisonment will lie where a person is unlawfully detained under a void process, or under no process at all, and cannot be maintain where the process is valid, no matter how corrupt may be the motives of the person suing out the process or how unfounded the imprisonment may be." Williams v. Smith, 179 Ga. App. 712 (1986).

<sup>9</sup> "Where detention is maliciously procured by civil process, the appropriate cause of action would be for malicious use of process." Id. at 714.

<sup>7</sup> Licensed physician, licensed psychologist, and licensed clinical social workers can initiate this process under Georgia law.



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tient's doctor visit, he makes the comment, in a grave fashion: "I am just going to go kill myself."

### Discussion:

There are several steps a doctor should take to make sure to avoid potential liability in the event this person actually did thereafter commit suicide, and also to avoid liability for preventing this person from leaving.

First, the doctor must make a determination about the potential danger this patient poses. This determination should be made based on the patient's full medical file, and most importantly on the patient's recent actions, communications, and behaviors. These could have been witnessed by the treating doctor, other hospital staff, or might have been reported by family member. In short, a doctor must exercise reasonable care to address the potential danger implied by the patient's statement, based on all the information reasonably available to him. To do so, the doctor must review the patient's complete *and* most recent file for indications that the patient might be a suicide threat, *and* should also interview the patient about that statement and his concerns.

Second, if the decision is made that a substantial risk exists, the doctor must pursue an appropriate course of action available to him, including: Prescribing or changing medicine, other specialized treatment, suggesting voluntary commitment to a facility, initiat-

ing restraint of the patient, involuntary outpatient options, or involuntary inpatient commitment.

Again, the doctor must proceed such that he is reasonably assured that: 1) He has exercised the appropriate skill and care to address his concerns; and 2) if based on this assessment, he reasonably believes the patient presents *substantial risk of imminent harm* to himself or others—the doctor/provider should proceed with appropriate steps under his power, up to and including the initiation of involuntary commitment under O.C.G.A. § 37-3-41, and restraint of the patient where appropriate (this process includes completion of "physician's certificate" and promptly notifying police of the certificate if the patient has left the facility against doctor's advice). **Again**, adherence to the statutory procedures is key, because good faith compliance to admission/discharge requirements of the involuntary admission statute confers statutory immunity for admission/discharge upon the compliant individual.

### O.C.G.A. § 37-3-4.<sup>10</sup>

#### *Hypothetical 2*

Hypothetical number two contains the same circumstances as number one, but rather than making his suicide threat to his doctor, the patient makes the threat to a hospital nurse as he is leaving the facility, having been treated by his doctor for an unrelated appointment (not mental treatment).

### Discussion:

This hypothetical raises the problem of potential liability even though the physician has *no actual knowledge* of any suicide risk, and illustrates the need for prompt, coordinated, and documented action by a medical facility. Specifically, the nurse in this scenario should ask the patient to wait and promptly report this to the treating physician, so the doctor can make any initial personal inquiries before the patient leaves, and consult the patient's remaining medical file. If the nurse *fails*

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<sup>10</sup> When the physician begins the process of involuntary commitment, care must also be taken to avoid potential liability based on the restraint by the hospital staff, and/or police inherent in the process, to formally execute the certificate, and to conduct all examinations required by the statute without delay. If the physician shows good faith compliance with the statutes, he gains statutory immunity for his role in the admission/discharge process. Further, adherence to the process, will protect the physician and the hospital from a claim for false imprisonment, as this adherence will negate the necessary "unlawful" element from that claim.

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to report this information to the doctor, the knowledge could still be imputed to the physician and the overall facility for purposes of liability.

### *Hypothetical 3:*

Hypothetical number three is the same as number two, but after making his suicide threat to the nurse, the patient indicates his intent to leave the facility, despite the nurse's request that he stay. A physician is **not** immediately available to consult. The nurse appropriately gives notice up the chain of command and ultimately an immediate decision is required of the risk manager.

### Discussion:

The hospital of course is presented with a conundrum under the statute. The hospital cannot, in advance, secure immunity for its restraint of the patient by its employees without a physician's evaluation. However, a hospital still risks malpractice liability for failing to make a decision concerning potential "imminent harm" under the statute. In this situation, the hospital should, within the time constraints provided: Review all charting concerning the patient, discuss the patient with nurses and other medical providers with most knowledge of the patient, and make a good faith decision concerning whether the imminent harm standard is met. If the decision is made to restrain the patient, the hospital should obviously seek immediate compliance with the statute by obtaining phy-

sician evaluation, certification and other statutory requirements.

To restrain a patient, the hospital has two possible choices. First, if the patient is still on the facility grounds, the hospital may have staff bring the patient back into the facility for evaluation under the statute. Second, if the patient has already left the facility, the hospital may execute a Georgia 1013 whereby a *peace officer* will bring the patient in to a medical examination facility. In the former scenario, where the medical staff actually restrains the patient, the hospital must take care that the statutory steps of evaluating, transferring, and involuntary committing are completed without delay, or risk losing the immunity protection under the statute, and possibly losing its "lawful restraint" defense to a claim of false imprisonment.

## II. Patient Elopement Policy Recommendations

Any policy to prevent patient elopement, once a patient is presented *who has already been issued a 1013 certificate or determined to be potentially dangerous*, should serve two major functions. The first (and obvious) purpose is to actually prevent patient elopement, and the second is to protect the medical care provider from exposure to liability in the event that an elopement does occur.

An effective policy should provide clear, purposeful, and efficient steps addressing the 1013

patient from patient intake/assessment through discharge or through all post-elopement responses.

### Step 1: Assessment: Elopement Risk

In the context of general elopement policy, a 1013 patient is likely already at the upper level of "elopement risk" and likely requires the higher level of supervision as a result of the potential danger posed by the patient which led to the 1013 in the first place. The key here is that each patient should be assessed *at admission* for risk of elopement, and the policy should have defined procedures flowing from the attendant predetermined level of risk.

### Step 2: Incorporation of Policy

The 1013 Policy for elopement should be integrated into the facility's general policy for elopement, for simplicity, efficiency, and to avoid lapses/errors. Thus, the level of security, monitoring, restraint, and the personnel involved in any given department should be clearly established, and documented at all steps. The policy should address available means of prevention: rooms, equipment, restraints, security officers or special employees to observe the patients, bed alarms, chair alarms, door alarms, wander alarms, coded entry/exit, and physical/medical restraints.



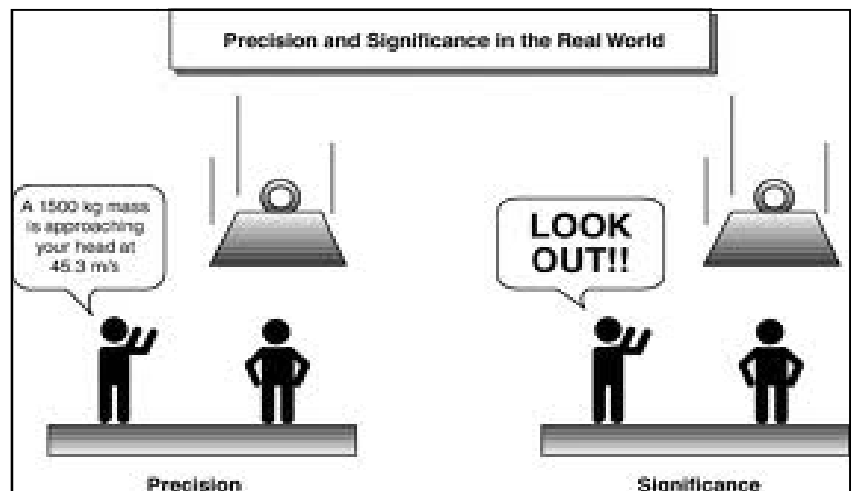
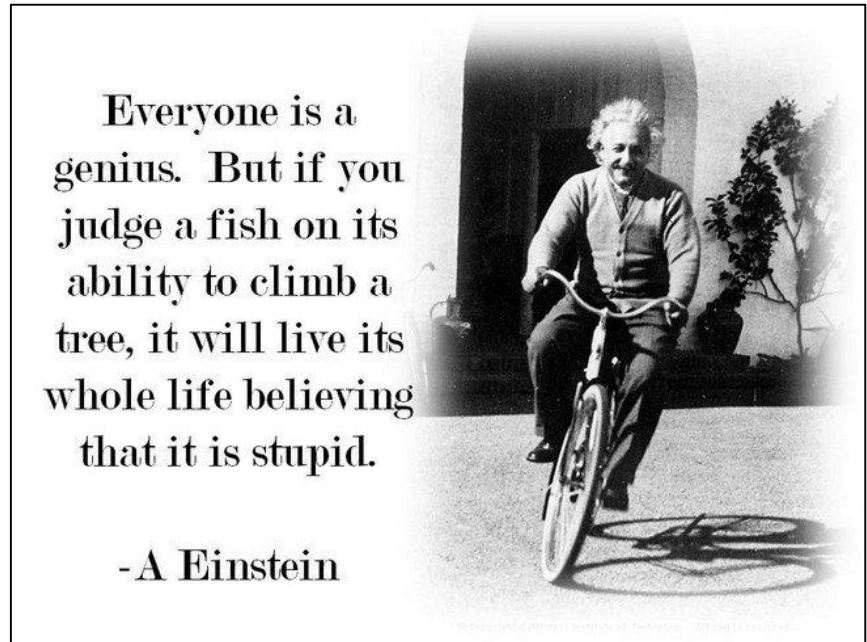
## Patient Elopement from 1013

### Step 3: Policy for when Elopement Occurs

When an elopement or possible elopement occurs, a clear step-by-step planned response is key, so that an efficient and coordinated response is effected rapidly, and any results are documented and acted upon without delay.

This policy should consist of at least the following requirements: 1) Consult immediately with the physician with most knowledge of the patient; 2) consult with nurse and hospital staff with most knowledge of the patient; 3) review all charting concerning the patient; 4) decision concerning imminent harm to be made by risk manager or most senior employee available; 5) document in detail the basis for the "imminent harm" decision; and 6) if not already accomplished due to time constraints, immediately obtain physician evaluation and certification in order to secure statutory compliance.

A defendant medical provider that has a thorough policy addressing the admission, evaluation, discharge, and elopement of 1013 patients, and that can demonstrate that policy was followed can effectively reduce its risk of liability in the event a patient elopes, causes harm to himself or others, or elects to sue for false imprisonment. An effective policy tailored to the individual practice can minimize liability and reduce the complex potential legal issues to a manageable practical level.



## Letter From the President

It's hard to believe the ASHRM Conference is behind us and soon the year will be ending. It was great to see so many of our members in Phoenix. I hope everyone had a great experience as well as some fun.

Now Ashley and Kristin are in the process of planning our winter meeting. I hope you will be able to join us for another great session.

It's also time to begin processing your request for GSHRM Membership Renewal for 2012. Remember, all memberships expire as of December 31, 2011. Please send your membership fee for \$85 to the Membership Chair prior to December 31. You will not have access to the website after December 31 until your membership is reinstated. Please go to the website and update your personal account information. We need to make sure we have your current title, e-mail address, etc.

As you renew your membership, try to think of someone in who is not a member and ask them to join you at our winter meeting. This is one way for the person to see the potential benefits of being part of our organization.

Finally, I want to thank you for your continued support this past year and a special thank you to our sponsors. Have a wonderful holiday season everyone.

*Debra*

Debra Scott

Memorial University Medical Center  
2011-2012 GSHRM President

