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THE FUTURE OF EMERGENCY DEPARTMENT
LIABILITY AFTER THE
RAVENSWOOD HOSPITAL INCIDENT:
REDEFINING THE DUTY TO TREAT?

*Kristine Marie Meece**

INTRODUCTION

A teenage boy is critically injured on the streets of a large urban city.¹ The victim of gang violence, he has been shot, and is hemorrhaging from the wound.² Knowing there is a hospital nearby, his friends assist the boy as far as he can walk—to within one half block of the hospital's emergency department (ED) entrance.³ There, the boy collapses on the pavement in hypovolemic shock, rapidly bleeding to death.⁴ His friends frantically dash into the ED, begging for medical assistance; however, no doctors or nurses leave the hospital premises to tend to the victim, citing a hospital policy that forbids staff from leaving the grounds to render care in emergency situations off-campus.⁵ Instead, the ED staff call 911 and instruct the boy's friends to await an ambulance.⁶ A police officer at the

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¹See Lola Smallwood, *Witnesses Say Hospital Refused to Help Dying Teen*, CHI. TRIB., May 18, 1998, Metro Chicago, at 1; *Dateline NBC: Chicago Hope?* (NBC television broadcast, June 2, 1998); *CBS This Morning* (CBS television broadcast, May 19, 1998).

²See Marcus Franklin, *Local Hospitals Would Have Helped Boy*, DAYTON DAILY NEWS, May 25, 1998, Metro Today, at 1B; Smallwood, *supra* note 1, at Metro Chicago 1; *CBS This Morning*, *supra* note 1.

³See *CBS This Morning*, *supra* note 1.

⁴See *id.*

⁵See *id.*

⁶See *Ravenswood: A Dilemma for All Risk Managers*, HEALTHCARE RISK MANAGEMENT, July, 1998; Smallwood, *supra* note 1, at Metro Chicago 1; *CBS This Morning*, *supra* note 1.

scene eventually manages to assist the boy inside the ED.⁷ However, within minutes he succumbs to his fatal injury.⁸

This scenario is a true story that occurred in May 1998 at Ravenswood Hospital (Ravenswood) in Chicago, Illinois.⁹ The boy's name was Christopher Sercye (Sercye).¹⁰ Since the incident, Ravenswood's policy mandating that staff must not leave the premises to care for a patient has been severely criticized.¹¹ In response, hospital officials state that contrary to some accusations, Ravenswood staff did not callously refuse to render care to the boy.¹² Although they have revised their policy since this incident, hospital administrators maintain that it served two very important purposes: protecting staff from potentially violent situations on the street, and maintaining their duty to care for ED patients already inside the hospital.¹³ Moreover, Ravenswood asserts that it was not an appropriate medical center for treating Sercye due to the emergent surgical nature of his injuries.¹⁴ Even if the boy had been in an ambulance, Ravenswood would have been bypassed in favor of one of the Chicago area trauma centers because Ravenswood is not equipped to handle the type of injuries sustained by Sercye.¹⁵ Finally, there is no Illinois state or federal law stating that emergency department staff must leave hospital grounds to care for emergency victims.¹⁶

⁷See *Ravenswood: A Dilemma for All Risk Managers*, HEALTHCARE RISK MANAGEMENT, July, 1998.

⁸See *id.*

⁹See Smallwood, *supra* note 1, at Metro Chicago 1; *CBS This Morning*, *supra* note 1.

¹⁰See *Ravenswood: A Dilemma for All Risk Managers*, HEALTHCARE RISK MANAGEMENT, July, 1998.

¹¹See Franklin, *supra* note 2, at Metro Today 1B; *Ravenswood*, *supra* note 6; *Dateline NBC*, *supra* note 1; *CBS This Morning*, *supra* note 1.

¹²See *Practice Medicine, Not Law*, CHI. SUN-TIMES, May 19, 1998, Editorials, at 23.

¹³See *Ravenswood*, *supra* note 6.

¹⁴See Kathryn J. McIntyre, *Commentary: Make Common Sense Part of the Policy*, BUS. INS., May 25, 1998, at 53.

¹⁵See *Dateline NBC*, *supra* note 1. Ravenswood Hospital would have been bypassed by an ambulance in favor of one of Chicago's level I trauma centers that are properly equipped and staffed twenty four hours a day to handle traumatic surgical emergencies like Sercye's. See Chris Petrakos, *ER Admission Policies Addressed*, CHI. TRIB., Oct. 7, 1998, *Nursing News*, at 3 (describing the difference between level I trauma centers and other hospitals within the Emergency Medical Services network).

¹⁶See generally, John Blair, *Commentary: Working Toward a Full Recovery: Hospital CEO Gets Crash Course in Crisis Management After Boy's Death*, MODERN HEALTHCARE, July 13, 1998, at 36 (discussing no formal obligation to treat an individual not on hospital property).

Responding to threats from the Health Care Financing Administration (HCFA) that their Medicare participation would be discontinued unless the policy was immediately revoked, Ravenswood amended the policy.¹⁷ The revised policy provides for designated hospital staff to be "on-call" twenty-four hours a day to render emergency care to patients in the "immediate vicinity" of the hospital.¹⁸

It is true that no Illinois or federal law exists that mandates emergency departments render emergency care to patients off hospital grounds. Therefore, Ravenswood staff acted within the law by refusing to treat Sercye. However, there remain some unresolved issues in light of the Ravenswood incident regarding the future of emergency department liability. The Background section describes the federal Emergency Medical Treatment and Active Labor Act (EMTALA) as it currently applies to emergency situations. The Analysis section includes arguments about whether liability under EMTALA could be extended to cases such as the Ravenswood incident. In addition, the Analysis section discusses whether, despite EMTALA, public policy requires hospitals to take on responsibility for emergency situations arising in the "immediate vicinity" of the grounds. The Impact section identifies potential problems Ravenswood may encounter in implementing its new policy, as well as whether the Illinois Good Samaritan Act¹⁹ can offer protection to staff who render assistance in a situation similar to that of Christopher Sercye.

BACKGROUND

The Emergency Medical Treatment and Active Labor Act

EMTALA is a federal statute that imposes a duty on hospitals receiving federal funding to provide appropriate medical screening to any patient who comes to the ED seeking treatment.²⁰ If the ED determines that an emergency medical condition²¹ exists, the hospital must provide for either

¹⁷See *HCFA Approves Change After ER Controversy*, HEALTHCARE RISK MANAGEMENT, Aug., 1998, at 102.

¹⁸Petrakos, *supra* note 15, at Nursing News 3.

¹⁹745 ILL. COMP. STAT. ANN. 49/2-15 (West 1998).

²⁰See *Johnson v. University of Chi. Hosp.*, 982 F.2d 230, 233 n.7 (7th Cir. 1992); 42 U.S.C. § 1395dd (1998).

²¹"Emergency medical condition" is defined in the statute as "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—(1) placing the

such treatment as required by the condition, or, if that ED is not capable of rendering the required treatment, for transfer of the patient to a qualified medical facility once the individual is stabilized.²² Originally, the statute was passed to prevent hospitals from making treatment decisions based on a patient's ability (or inability) to pay -- a practice that had become epidemic in the United States prior to EMTALA's enactment.²³ Referred to as "dumping," emergency departments denied treatment or transferred patients to other hospitals if they were unable to pay the bill, without regard for the patient's physiologic condition.²⁴ Violations of EMTALA are punishable by individual civil personal injury lawsuits for actual damages, as well as civil monetary penalties of not more than \$50,000 per violation.²⁵

ANALYSIS

To establish a violation of EMTALA, a plaintiff must prove three things: the hospital in question is covered by the statute, the patient arrived at (or "came to") the hospital seeking treatment, and either the hospital did not properly screen the patient or the hospital sent the patient away before stabilizing the condition.²⁶ A hospital is covered by EMTALA if it receives federal funding.²⁷ Since Ravenswood Hospital receives Medicare funding, it is covered by EMTALA. However, there are no cases that directly address the issue of whether EMTALA applies to emergency victims who are within close proximity to, but not physically on hospital property.²⁸ Furthermore, no litigation has come out of the Ravenswood incident. If litigation were commenced, the issue of Ravenswood's liability would turn on a court's definition of when a patient "comes to" the ED for purposes of EMTALA. Some of the following contentions concerning EMTALA could foreseeably be made.

health of the individual . . . in serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part." 42 U.S.C. § 1395dd (1998).

²²See *id.*

²³See *Johnson*, 982 F.2d at 233 n.7.

²⁴See *id.*

²⁵See 42 U.S.C. § 1395dd (1998).

²⁶See *id.*

²⁷See *Johnson v. University of Chi. Hosp.*, 982 F.2d 230, 232-33 (7th Cir. 1992).

²⁸It has been asserted that if an individual is not on hospital property, EMTALA regulations are not applicable. See W. Richard Bukata, *Patient Transfer Regulations—1998 Update*, EMERGENCY MED. & ACUTE CARE ESSAYS, Sept. 1998.

A plaintiff might argue that EMTALA applies to the hospital in this situation by interpreting the statute broadly. With a broad interpretation of EMTALA, one could argue that the statute encompasses any patient requesting medical assistance, regardless of location. In this regard, a plaintiff could argue that a victim's mere request for medical assistance satisfies the "coming to" requirement of EMTALA, and that actual physical presence inside the ED is not required for a patient to qualify for emergency assistance under the statute. For example, Sercye's friends arrived at the ED begging for help.²⁹ A plaintiff could argue that those pleas could be construed as Sercye's request for assistance, which satisfies the "coming to" element of the statute; therefore, the hospital should be held liable.

The defense might argue that a patient "comes to" the ED when he physically arrives inside the doors of the hospital, and urge a narrow interpretation of EMTALA. In this regard, a Seventh Circuit case could be cited where a patient who was never physically inside a hospital facility was held not to have "come to" the ED for purposes of EMTALA. In *Johnson v. University of Chicago Hospitals*,³⁰ the defendant hospital declined to accept a patient into its ED through the emergency medical system's telemetry system operator because the hospital had declared itself on "partial bypass."³¹ Paramedics had contacted the defendant hospital requesting authorization to bring an emergency victim to its ED, which was only five blocks from the scene.³² However, the hospital instructed the paramedics to take the patient to another hospital, and the patient died during the transfer.³³ The court, in construing EMTALA, held that since the patient was never physically present at the hospital, that she never "came to" the hospital for purposes of EMTALA liability.³⁴ Therefore, EMTALA was not applicable, and the hospital was not liable under the statute.³⁵

A hospital in Ravenswood's situation might attempt to escape EMTALA liability by analogizing *Johnson* to the facts. Like the plaintiff patient in *Johnson*, Christopher Sercye, although very close to the ED

²⁹See *Practice Medicine, Not Law*, *supra* note 12, at 23.

³⁰*Johnson*, 982 F.2d at 230.

³¹See *id.* at 231.

³²See *id.*

³³See *id.*

³⁴See *id.* at 233.

³⁵See *Johnson*, 982 F.2d at 233.

entrance, was never actually on hospital property.³⁶ Therefore, a hospital could argue that like the *Johnson* case, the statute does not apply; thus escaping liability.

A plaintiff might distinguish *Johnson* on its facts and say that the two situations are completely different because in *Johnson*, the patient was already inside an ambulance, receiving medical attention, and en route to the appropriate facility within the emergency medical service network.³⁷ In the present situation, however, Sercye was lying just feet from the only ED available to him, and had no medical personnel tending to his care.³⁸ Therefore, a plaintiff would argue that the court was correct in denying EMTALA liability in *Johnson*, but should apply it to the present facts because Sercye received no medical attention while en route to the hospital.³⁹

A plaintiff could also say that even if a court were to hold that Sercye did not "come to" the hospital for purposes of EMTALA, public policy demands that EMTALA be extended such that ED staff should be required to administer care to someone in need of emergency care who is in close proximity to hospital grounds. For example, as one editorial stated, "rigid adherence [to Ravenswood's policy of not leaving hospital premises] seems absurd when a person lies wounded such a short distance from emergency room personnel."⁴⁰ Even Ravenswood Hospital's president and chief executive officer admitted that he believes "the policy did not work in the spirit in which it was written⁴¹ more than a decade ago . . ."⁴² The policy, according to some, became "dysfunctional"⁴³ at the point where staffers observed strict adherence to it instead of saying, "[s]crew

³⁶See Franklin, *supra* note 2, at Metro Today 1B; *Dateline NBC*, *supra* note 1; *CBS This Morning*, *supra* note 1.

³⁷See *Johnson v. University of Chicago Hosp.*, 744 F. Supp. 510 (Ill. 1991).

³⁸See Smallwood, *supra* note 1, at Metro Chicago 1.

³⁹See *id.*

⁴⁰McIntyre, *supra* note 14, at 53.

⁴¹Ravenswood Hospital's policy was originally written for the dual purpose of protecting hospital staff from potentially dangerous situations on the street and to ensure that its current ED patients were properly attended. Neither of these situations was of such concern on the day of Sercye's death that the policy required strict adherence. See *Ravenswood*, *supra* note 6.

⁴²Bruce Japsen, *Call for Common Sense: Hospitals Rethink Policies After ER Denies Dying Boy Care*, MODERN HEALTHCARE, May 25, 1998 at 24.

⁴³Bob Groves, *Teen's Death Outside ER Poses Dilemma for Hospitals*, THE RECORD, May 20, 1998, News, at L01.

policy, I'm getting that kid in here NOW."⁴⁴ Other commentators expressed that "compassion should have overruled fears of litigation . . . [and] any attempt . . . to save the boy's life would have been in keeping with the oath they took when they became doctors and nurses."⁴⁵

The defense might assert that public policy does not mandate that EMTALA be extended. In this regard, the hospital might say that to adopt such public policy would be to possibly abandon patients in the ED and expose staff to potentially dangerous situations on the street.⁴⁶ Considering Ravenswood Hospital's location in Chicago's inner city, it is not unreasonable to think that the violence that so often plagues the streets would also surface around the campus of the hospital. Moreover, the argument concerning difficulty defining "immediate vicinity" could be presented. "Just how far the victim is from the hospital becomes a logistical problem for staff members," and is a slippery slope consideration.⁴⁷ Is the immediate vicinity one block, within shouting distance, two blocks, one hundred yards, across the street, or within seeing distance? The hospital could argue that the problem of implementation is unreasonable, and that hospitals should be free to decide whether to adopt policies like their new one, not be forced to do so.

A plaintiff may retort by pointing out that other states, such as Minnesota, have Good Samaritan laws that actually require witnesses to render "reasonable assistance."⁴⁸ In other states, such as Massachusetts and New Jersey, many hospitals have policies of aiding anyone in need of medical assistance both inside the hospital and on adjacent streets,⁴⁹ and that Illinois law should be amended to require the same.

Ravenswood hospital could try to circumvent EMTALA completely by arguing that the present situation is not what Congress had in mind when they enacted the statute. Since EMTALA was originally enacted to prevent hospitals from "dumping" patients who are unable to pay,⁵⁰ and

⁴⁴MINN. STAT. § 604A.01 (1998); Richard Roeper, *In Wake of Chicago Case, We Need "Good Samaritan" Law*, STATE JOURNAL-REGISTER, May 24, 1998, Editorials, at 23.

⁴⁵*Practice Medicine, Not Law*, *supra* note 12, at 23.

⁴⁶These two considerations were precisely the problems that Ravenswood's original policy sought to prevent. See Petrakos, *supra* note 15, at 3.

⁴⁷Groves, *supra* note 43, at L01.

⁴⁸See Roeper, *supra* note 44, at 23.

⁴⁹See Groves, *supra* note 43, at L01; Jessica Heslam, *Local ER Staffs Can Treat Outside; Chicago Death Appalls Hospitals*, THE PATRIOT LEDGER, May 20, 1998, News, at 12.

⁵⁰See *Johnson*, 982 F.2d at 233.

since Ravenswood did not deny treatment to Sercye based on his financial status, a defendant could argue that EMTALA is completely inapplicable to this situation.

IMPACT

Whatever the result of any litigation that ensues as a result of the Ravenswood Hospital incident, the impact may be extreme. If a court were to extend EMTALA liability, Illinois hospitals would immediately encounter problems if their policies did not provide for care of off-campus patients in need of emergency treatment. Conversely, if a court were to refuse to apply EMTALA to the situation at hand, hospitals state-wide could feasibly circumvent the statute in similar situations in the future.⁵¹

Although there has been no litigation to date, in March 1999, Ravenswood Hospital signed a mutual agreement with the inspector general of the Department of Health and Human Services (DHHS).⁵² Pursuant to the agreement, Ravenswood Hospital was fined forty thousand dollars for allegedly violating EMTALA; however, the hospital admitted no wrongdoing in the matter.⁵³ The agreement also provides that the hospital will "remind the community that it accepts all patients with emergency medical conditions. It promised to buy two quarter-page advertisements over the next year in Sunday editions of the Chicago Sun-Times declaring that Ravenswood examines patients 'without delay and regardless of their ability to pay.'"⁵⁴ Thus, EMTALA may have already been effectively extended.

Notwithstanding Ravenswood's agreement with DHHS or a court's future ruling on the issue, HCFA has also demonstrated that it also has the power to extend applicability of EMTALA by threatening to kick

⁵¹It is not outrageous to consider the possibility that this sort of situation could happen again. Ravenswood's chief executive officer indicated that just since the revision of the ED policy to include service to the immediate vicinity, there have been several occasions on which ED staff had to leave the premises to attend emergency situations at least one block away. See Petrakos, *supra* note 15, at 3.

⁵²See *Hospital That Didn't Treat Teen is Fined*, CHI. TRIB., Mar. 13, 1999, News, at 5; *Hospital That Failed to Aid Dying Teen to Pay \$40,000*, THE BOSTON GLOBE, Mar. 13, 1999, National/Foreign, at A21.

⁵³See *id.*

⁵⁴*Hospital that Failed to Aid Dying Teen to Pay \$40,000*, *supra* note 52, at A21.

Ravenswood out of the Medicare system.⁵⁵ Based on HCFA's requirement, Ravenswood would not be civilly liable for refusing to treat an off-campus emergency victim (as they would if they were in direct violation of EMTALA).⁵⁶ However, HCFA is responsible for determining hospitals' eligibility for Medicare reimbursement, which is a substantial percentage of a hospital's income.⁵⁷ Therefore, by threatening to discontinue Medicare participation, HCFA's demand is the functional equivalent of extending EMTALA to require ED staff to render emergency care to victims at off-campus locations.⁵⁸

Aside from other issues, Ravenswood's revised policy presents inherent problems in implementation. First, the new policy states that two ED personnel⁵⁹ are available twenty-four hours a day to provide emergency assistance to anyone requesting it in the "immediate vicinity."⁶⁰ However, the term "immediate vicinity" is ambiguous. Therefore, staff will not know in what situations they will be required to leave hospital grounds to render emergency care. The potential for litigation in this regard is obvious. If a patient needs care who is one block away, he will most likely receive it. However, what about a patient who is three blocks away? It is foreseeable that patients in the gray area of "immediate vicinity" who are denied emergency care by the hospital may sue to recover damages for harm suffered as a result of not having

⁵⁵See *supra* note 17, at 102. See also *Ravenswood*, *supra* note 6 (stating that HCFA threatened to cancel Ravenswood's Medicare participation within a month unless the hospital could prove it had changed the policy that led to the incident).

⁵⁶See *supra* note 17, at 102; 42 U.S.C. § 1395dd (1998).

⁵⁷See *Dateline NBC*, *supra* note 1 (stating that Ravenswood hospital was at risk of losing \$48 million dollars in Medicare funding).

⁵⁸This effect leads to the question of whether HCFA's demand is legally recognizable. If legislators had intended EMTALA to apply to situations arising off hospital grounds, they would have so indicated in the language of the statute. Amendments to federal legislation require much more than a demand from one entity. Regardless of whether hospitals may be held civilly liable under EMTALA for refusing to render care off-site, the practical effect of HCFA's action is that EMTALA is effectively extended such that emergency departments now have a duty to treat victims in the immediate vicinity. If this duty is breached, hospitals face forfeiture of Medicare reimbursement.

⁵⁹One physician and one staff nurse will respond to off-site emergencies. See *supra* note 17, at 102.

⁶⁰See *id.*

received emergency medical care to which they may have been entitled under the hospital's policy.⁶¹

Other problems in implementation include what equipment the staff is expected to carry with them to off-campus emergencies. There is no way to foresee the individual needs of emergency patients, except that suction, oxygen, medications, and other durable medical equipment is often required.⁶² These items are heavy and cumbersome to carry, regardless of the distance they must be carried. Additionally, should the staff be required to take a wheelchair or stretcher with them to every off-site situation? These considerations conjure up the image of two staffers scrambling to gather pieces of equipment and then running down the street attempting to push it or carry it on their backs, getting wheels stuck in potholes and tripping over cracks in the sidewalk. One may justifiably wonder if bringing equipment and supplies to remote locations is practical at all. What then, if anything, should staff bring with them to these situations is a question to be given consideration.

Another consideration is whether hospital staff is expected to transport off-site emergency victims into the ED. The possibility that a patient has sustained neck and back injuries must be taken into account if he is to be moved. According to Ravenswood's chief executive officer, staff have brought patients inside themselves since the new policy became effective.⁶³ However, a nurse from one suburban hospital has expressed a different view on transporting patients from outside the premises to the ED, stating that while she has several certifications, they do not include transport-nursing.⁶⁴ "That is something I would have to be cognizant of:

⁶¹Chicago aldermen proposed several city ordinances which would define the boundaries of "immediate vicinity." One proposal would require hospitals to treat emergency patients within 1,000 feet of the hospital. Another proposal would strip hospitals' general business licenses and impose fines of \$1000 on hospitals who refuse to treat patients within 150 feet of the facility. See *Practice Medicine, Not Law*, *supra* note 45, at 23.

⁶²"Crash carts" equipped with automatic defibrillators, cardiac monitors, and other supplies for cardiac arrest, for example, are very large, heavy and cumbersome to push down a hallway. Imagine trying to push one down a bumpy and busy street in the rain or snow.

⁶³See Petrakos, *supra* note 15, at 3.

⁶⁴Certification provides a mechanism whereby nurses can validate their expertise and demonstrate accountability to the public. It is required by some health care institutions in order to perform certain specialized nursing tasks. The American Nurses' Association offers certification for various areas of nursing, such as neonatal, operating room, oncology, and transport. Certain levels of expertise, education, experience, and examination scores are required to receive status as a certified specialty nurse. See SUZANNE C. SMELTZER and BRENDA G. BARE, BRUNNER AND SUDDARTH'S TEXTBOOK OF MEDICAL-SURGICAL NURSING 12 (7th ed. 1992).

practicing outside my scope.”⁶⁵ Thus another dilemma is presented—whether nurses who render emergency care to patients off-site should be certified in transport-nursing. This consideration cannot be ignored, because if bringing a patient in from an off-campus location is considered a “transport” and staff are not transport-nursing certified, it places them in the position of practicing outside the scope of their licenses, which potentially opens them and the hospital up to negligence liability.⁶⁶

Still another potential problem is hospitals with large campuses. At Ravenswood hospital, for example, some parts of the campus are two blocks from the ED.⁶⁷ Larger medical center campuses often span several city blocks, which poses an obvious question. What happens when a person in need of emergency assistance is just one block away from hospital grounds, but that person is four or five blocks from the ED? Are staff expected to traverse four or five city blocks to assist that patient? Certainly, by the time staff have traveled that far while pushing and/or carrying heavy equipment, they will be fatigued. Then the possibility exists that fatigue will affect their performance in rendering care. Furthermore, the equipment must be returned to the hospital. By the time the staff get back to the ED, they could be too fatigued to effectively care for their ED patients.

The underlying rationales behind Ravenswood’s old policy cannot be ignored, either. First, the interest of protecting staff from potentially violent situations outside the hospital is a real and valid concern.⁶⁸ Given the large number of violent crimes committed in large cities like Chicago, the safety of staff who are called to assist in off-campus emergencies must be given due consideration.⁶⁹ The potential for danger presents the question of how staff should assess the potential risks associated with entering a particular area to deliver emergency care. Should hospital security be summoned to scan the area before staff leaves the building? Should staffers have the option of determining the relative safety of the situation themselves once they have arrived on the scene? What, if during

⁶⁵Petrakos, *supra* note 15, at 3.

⁶⁶*See id.*

⁶⁷*See id.*

⁶⁸*See id.*

⁶⁹It is common knowledge that in some areas of Chicago, for example, while one particular city block may be relatively safe in terms of gang “territory” and activity, the very next block may be plagued with unlawful activity and therefore present a very real danger to the public. *See id.*

the course of the treatment, a violent situation arises: will staff be expected to remain with the patient, or should they flee the area? The potential for violence can only be determined on a case-by-case basis, and it seems elementary that under no circumstances should staff be sent out to face a potentially violent situation. However, it is very unclear what the scope of the staff's obligations to the patient would be if violence were to arise at the off-site location.

The second rationale behind Ravenswood's old policy is the hospital's duty to treat ED patients who are already inside the hospital.⁷⁰ "The safety of the patients already in the emergency department should be the hospital's first priority."⁷¹ For people to go outside, therefore, proper staffing in the ED must be available to replace the nurse and physician who left.⁷²

How, then, will Ravenswood reconcile the important interests served by its old policy with the new policy? The director of clinical administrative emergency services for the Metropolitan Chicago Health Care Council indicated that the hospital's guidelines should take into account the services available through the Emergency Medical Services (EMS) system, and that responders from hospitals should only be summoned in true emergencies.⁷³ The president and chief executive officer of Ravenswood Hospital, John E. Blair, stated that their first response is to call 911.⁷⁴ "The second response, depending on the proximity, is to either go to the site with either emergency personnel or security personnel. If it is three or four blocks away, we send a security guard with a walkie-talkie and he's going to let us know what is going on while waiting for 911."⁷⁵ Mr. Blair went on to say that on the few occasions since the new policy was enacted that staff actually went to the scene, they assessed the situation "and either waited for 911 or brought the patient in" themselves.⁷⁶ It remains to be seen how the potential problems that staffers will encounter in continuing to implement their policy will be resolved.

⁷⁰See Petrakos, *supra* note 15, at 3; Blair, *supra* note 16, at 36.

⁷¹Petrakos, *supra* note 15, at 3.

⁷²See *id.*

⁷³See *id.*

⁷⁴See *id.*

⁷⁵See *id.*

⁷⁶Petrakos, *supra* note 15, at 3.

It is worth noting that physicians and nurses may harbor legitimate fears of civil liability associated with “bad” outcomes of treatment rendered at off-site locations. It is easy to imagine an emergency situation at a remote location where equipment fails, or the required equipment and supplies are not available, and the patient dies or sustains permanent injuries as a result. The question arises whether the Illinois Good Samaritan Act⁷⁷ (the Act) could provide a shield from liability for this type of situation. The Act was promulgated as protection for health care providers who volunteer their services in emergency situations, and was intended to “encourage persons to volunteer their time and talents . . . to help others.”⁷⁸ It does not impose an affirmative duty to render emergency care, but shields from liability those health care professionals who, in good faith and without prior notice of the illness or injury, offer emergency assistance without fee to a victim.⁷⁹ However, the Act will probably not afford staff protection from civil liability in a case where a hospital has implemented a policy whereby staff are required to render off-site emergency assistance. In that scenario, because staff would be paid for their services rendered, the Act would probably not apply. A hospital could attempt to circumvent this problem simply by not billing the patient for care received at an off-site location. However, it remains to be seen whether a court would afford “Good Samaritan” protection to hospital staff in that situation.

A final consideration is if a court were to hold that from a policy standpoint, hospital emergency departments must render assistance to victims in the immediate vicinity of hospital grounds, there arises an issue of whether only ED staff are under this duty. What about a case where the ED cannot spare any staff to go off-campus — will other hospital staff be pulled from their units to attend the situation or to care for the ED staff’s patients while the ED staff is outside? What about when an accident occurs outside a physician’s office? Will those doctors be required to go outside and assist? What if the accident occurs outside the physician’s home? If, from a policy standpoint, a court determines that an emergency department has a duty to treat off-site victims, it is impossible to tell at what point on the slippery slope the duty to treat will end.

⁷⁷745 ILL. COMP. STAT. ANN. 49/2-75. (West 1998).

⁷⁸745 ILL. COMP. STAT. ANN. 49/2. (West 1998).

⁷⁹See 745 ILL. COMP. STAT. ANN. 49/2-75. (West 1998). The only exception to the Act is for willful or wanton misconduct. See *id.*

CONCLUSION

The future of emergency department liability is uncertain after the Ravenswood Hospital incident. It is certainly true that from one standpoint, to leave a boy dying in the street just feet away from a hospital emergency room seems like a cold disregard for human life. However, the rationales underlying Ravenswood's old policy are sound. As the Impact section illustrates, imposing a rule that would force emergency department staff to leave hospital grounds in every potential off-campus emergency presents many practical problems in implementation, not to mention considerable safety issues. It seems, therefore, that the most logical approach is to allow hospitals to formulate their own policies. To do this, a hospital should consider many variables such as the size of its campus and the location of its ED therein, the hospital's geographic location within a city, its placement within the emergency medical services network, the availability of staff, and the probability of staff encountering violence on the street. These considerations should be balanced and dealt with on a case-by-case basis by hospitals to ensure the safety for all involved.

Notwithstanding any legal/liability issues, HCFA may have already redefined and extended the duty to treat by threatening revocation of Medicare participation.⁸⁰ By demanding that Ravenswood assure them that a similar incident will never happen again, HCFA has set up a punishment system that, in implementation, effectively extends EMTALA's duty to include mandatory treatment of patients in the immediate vicinity of hospital grounds.⁸¹ As described in the Impact section, a blanket rule such as this has many problems that must be dealt with on a case-by-case basis. The practical effect of HCFA's demand may be that hospitals sacrifice quality in-patient care and the safety of their staff in order to ensure that Medicare reimbursement is never revoked. This consideration is compounded and complicated by Ravenswood's agreement with DHHS.⁸² Following the Ravenswood Hospital incident, the duty to treat seems ambiguous and has very unclear boundaries. It is, therefore, a grave situation that hospitals, staff, and patients are faced with from this point forward.

⁸⁰See *supra* note 17, at 102.

⁸¹See *id.*

⁸²See *supra* note 52.