



# LEGAL ISSUES IN INTERFACILITY TRANSFER

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ISSUE BRIEF

## Introduction

The Emergency Medical Services for Children (EMSC) Program recognizes the importance of critically ill and injured children receiving treatment at the hospital that is best equipped to care for them.<sup>1</sup> When children require specialized emergency care, the best course of action is often a transfer to a specialty hospital. However, an interfacility transfer raises questions of liability for the hospital and providers sending the patient as well as receiving the patient. The point at which the sending hospital gives up legal responsibility for the patient and the receiving hospital assumes responsibility may not be clear. In some cases, the sending hospital may send a patient with emergency medical services (EMS) technicians to the receiving hospital; in other cases, the receiving hospital may effectuate the transfer with its own staff in order to ensure a seamless transition. Transfers also can involve periods of joint consultation among staff at both hospitals over diagnostic, treatment, and transfer decisions. The allocation of responsibilities among the various parties can raise questions of legal liability.

This brief presents an overview of the law regarding the point at which liability can attach in the case of health care providers involved in inter-facility transfers. We review issues of liability related to medical direction provided during interfacility transfer. We also look at the liability of a sending hospital for the actions of a receiving hospital's transport team personnel who initiate treatment in the sending hospital prior to the transport. We close with a brief discussion of Emergency Medical Treatment and Active Labor Act (EMTALA) liability issues that can arise in the case of an interfacility transfer.

## Legal Responsibility for the Patient

A professional or institutional "duty of care" begins when a health professional or health care institution enters into a relationship with a patient, or what the law refers to as "commencing an undertaking."<sup>2</sup> The point at which the law considers a health care relationship to exist can vary; it can involve a formal agreement to assume health care responsibilities or can involve activities that, from a legal perspective, amount to the establishment of a provider/patient relationship. At the point when such a relationship is established, a health care professional or institution assumes a duty to act in a manner consistent with a reasonable standard of care. Resolving the question of whether the conduct and actions of the professional or institution fall below the reasonable standard is complex and fact-driven and entails comparing the conduct in question against the standard and norms of the profession. The threshold question, however, is whether the professional or institution had a duty to the patient.



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Traditionally, a physician-patient relationship begins when a physician undertakes to provide health care for a patient in exchange for payment.<sup>3</sup> In the modern world, however, a health care undertaking can commence without face-to-face contact, as a result of an electronic or telephone consultation or the agency relationships created through the use of residents and on-call systems.<sup>4</sup> Even where a physician has not met a patient, a physician-patient relationship may be created by implication when a physician directs the patient's treatment, as in the case of an on-call physician who issues orders for the patient's care which are executed by hospital staff.<sup>5</sup> Where the physician (or other health care professional) is acting as part of a hospital-based treatment system, liability can extend to the hospital under various theories of vicarious and corporate liability, including actual and ostensible agency and corporate liability.<sup>6</sup>

Where multiple physicians acting across health care institutions are involved in a patient's care, responsibility for care may be less clear and more diffuse. Merely consulting informally with a physician about a patient's care typically is not sufficient to create a physician-patient relationship, even if the consulting physician suggests a course of treatment.<sup>7</sup> At the same time, if the consultation is between an emergency room physician and an on-call or consulting specialist, the facts may suggest a greater involvement in the direction of patient care and liability may exist.<sup>8</sup>

The courts are divided on how extensive the involvement must become before a consulting physician will be found to have commenced an undertaking, and thus, to have owed a duty of care to a patient. In *Irvin v Smith*, the court held that no physician-patient relationship was created between a neurologist and a patient even though the neurologist consulted with the patient's treating physician regarding the proper course of treatment and agreed to perform the necessary surgical procedure the following day because the patient's condition deteriorated before the procedure could be undertaken.<sup>9</sup> Even where a physician has agreed to be the on-call specialist for emergency room patients, that agreement in some cases may not be enough to create a duty toward emergency room patients where the physician does not actually undertake to treat them.<sup>10</sup> Where an on-call physician does actually make a diagnosis and direct a patient's course of treatment, however, a physician-patient relationship can exist even though the physician has never met the patient.<sup>11</sup> In one recent case, the Tennessee Supreme Court explained:<sup>12</sup>

In light of the increasing complexity of the health care system, in which patients routinely are diagnosed by pathologists or radiologists or other consulting physicians who might not ever see the patient face-to-face, it is simply unrealistic to apply a narrow definition of the physician-patient relationship . . . . [W]e hold that a physician patient relationship may be implied when a physician affirmatively undertakes to diagnose and/or treat a person, or affirmatively participates in such diagnosis and/or treatment.

Applying the principles of these cases to interfacility transfer situations, the question thus becomes, for purposes of liability, when does an "affirmative" undertaking or participation begin? The answers will vary based on the jurisdiction in which a case arises and the level of involvement demanded by courts in particular states before an undertaking can be said to have commenced.<sup>13</sup>

In general, following the principles articulated in the above cases, a physician receiving a transferred patient would not be responsible for that patient until he or she actually undertakes to treat the patient, even if the receiving physician consults with the sending physician regarding the patient's care before the transfer. This situation was considered in the case of *Sterling v. Johns Hopkins Hospital*.<sup>14</sup> In *Sterling*, a woman with a complicated pregnancy presented at Peninsula Regional Medical Center (PRMC). The treating physician, Dr. Gray, made a diagnosis of severe pre-eclampsia and potential HELLP syndrome and placed Ms. Sterling on a magnesium sulfate drip. Dr. Gray contacted the Emergency Medical Resource

Center (EMRC)<sup>15</sup> to arrange for the patient's transfer to another hospital and was informed that Hopkins was the perinatal referral center.<sup>16</sup> Dr. Gray conferred with a Hopkins resident who conveyed the patient information to the attending physician, Dr. Khouzami. Dr. Khouzami called Dr. Gray and the two physicians decided that Ms. Sterling should be transferred to Hopkins. Although Dr. Gray requested that she be transferred by helicopter because ground transport would take approximately two and a half hours, Dr. Khouzami believed that ground transport was acceptable, which was consistent with state emergency transport procedures.<sup>17</sup> Dr. Gray arranged for Ms. Sterling to be transferred by ambulance, but she suffered an intraventricular hemorrhage en route and died.<sup>18</sup> The court concluded that even though, as a consulting specialist, Dr. Khouzami was involved in selecting the mode of transportation, the facts nonetheless showed that Dr. Gray never relinquished control of the patient's care. As a result, no physician-patient relationship between Dr. Khouzami and Ms. Sterling existed, and thus, no liability could be found despite Khouzami's involvement in selecting the mode of transportation as the consulting expert. The court explained its reasoning as follows:<sup>19</sup>

To summarize, Hopkins, through its agent, confirmed a diagnosis of a patient it had no contact with whatsoever, confirmed that the treatment given was appropriate and agreed to the transfer of that patient. None of these actions were binding upon the primary physician, who could observe that patient's deteriorating condition. . . . We thus cannot assume that a hospital accepting a transfer owes the same duties as the transferring hospital, as the accepting hospital is not currently treating the patient and thus has not established a responsibility toward the patient. Furthermore, the accepting hospital is unable to examine the patient to make informed decisions. We will not extend to such hospitals a duty of medical care where the patient remains under the supervision and care of her treating or attending physician.

Under this reasoning, the treating physician at the sending hospital would retain sole legal responsibility for the care of the patient being transferred as long as the treating physician in the sending hospital is deemed to have retained the authority to control the patient's care. In *Sterling*, despite the existence of a consultation with a specialist, the facts suggested that it was the treating physician at the sending hospital who had the final say regarding the mode of transportation for the patient transfer.

The result in *Sterling* is consistent with the policy statement of the American College of Emergency Physicians regarding interfacility transfers. This policy provides that sending physicians are responsible for initial patient assessment and determining the level of care for the patient during transfer, while receiving physicians are only responsible for ensuring that the receiving hospital is capable of providing the necessary care.<sup>20</sup>

As noted previously, it is important to remember that the *Sterling* case is a Maryland state case. Courts in other states may arrive at different conclusions under similar facts, particularly where there is evidence that the physician at the receiving facility assumed some degree of control over patient care. Thus, where a sending physician actually relies on a receiving facility specialist to make a diagnosis and direct treatment rather than simply accept a transfer, a fact finder could conclude that the requisite line had been crossed, that the receiving physician had undertaken to provide care and had a duty of care before the patient was actually transferred.<sup>21</sup> This is a likely scenario when the patient is being transferred because the staff at the sending hospital lacks the medical expertise required to provide necessary care.

These cases illustrate the value of interfacility transfer agreements, which can help clarify the respective duties of care in a transfer case. Such agreements can help clarify the point at which the receiving hospital assumes a duty to the patient being transferred and describe which duties are assumed and which duties remain with the sending hospital.

## Sending Hospital Liability for Transport Team from Receiving Hospital

In some patient transfer situations, the receiving hospital will send a transport team to the sending hospital to help ensure seamless medical care for the patient during the transfer. The transport team members are not employees of the sending hospital and may not have privileges to practice medicine at the sending hospital. However, they may provide medical treatment to the patient in preparation for the transfer while the patient is still under the control of the sending hospital and prior to discharge. The question is whether liability for the sending hospital can arise if the transport team, acting within the confines of the sending hospital, engages in conduct prior to or during discharge that falls below the professional standard of emergency transfer care.

The answer can be quite variable. Where the facts suggest that the patient is under the control of the receiving facility's professionals who are acting pursuant to an agreement with the sending hospital, the sending hospital and its staff may avoid liability. Under traditional notions of vicarious and corporate negligence, it is possible that liability can exist against the sending hospital and its staff if the terms of the negotiated agreement fail to anticipate problems with a "pass-off" with reasonable certainty or if the actual transfer from the sending hospital to the receiving hospital is negligently executed.

It is true that with certain exceptions, physicians practicing in hospital settings tend to be considered independent contractors.<sup>22</sup> But in the case of interfacility transfers, the outcome may be different. Putting aside matters of actual agency (*i.e.*, whether the physician is employed by the hospital), patients in need of highly specialized transfers may be considered by courts to have looked to the facility, rather than a particular physician, for the safe effectuation of a transfer, particularly if the transfer is out of an emergency room or following a post-admission medical emergency. Furthermore, basic principles of institutional duty suggest that hospitals who are parties to transfer agreements maintain an obligation to ensure the reasonableness of both the transfer agreement and the actual pass-off to the receiving hospital staff.

Hospitals may be liable for the actions of physicians who are employees of the hospital under a theory of respondeat superior, just like all employers.<sup>23</sup> In addition, courts increasingly have been willing to impose a duty to supervise the care provided by physicians in the hospital, under a theory of corporate negligence, particularly where the patient has sought care from the hospital (as in emergency medical treatment) rather than the individual physician.<sup>24</sup> Some courts have held that hospitals have a nondelegable duty to provide competent care to patients who seek emergency care from the hospital.<sup>25</sup> Finally, hospitals may be found liable for the actions of providers and others within its walls based on a theory of apparent agency. That is, where a hospital has held itself out as providing certain services (such as emergency care), it can be liable for the actions of individuals providing those services within the hospital if the patient reasonably believes the individual is an agent of the hospital.<sup>26</sup> The legal standards for finding apparent agency vary from state to state.<sup>27</sup>

In the case of a transport team whose members are not employees of the hospital, do not have staff privileges at the hospital, and are following the medical direction of the receiving hospital, it would appear that the duty of care to the patient has been assumed by the receiving hospital and its staff. The situation would be similar to a private physician treating a patient in the hospital, where the hospital is not directing the physician to treat the patient or supervising the treatment.<sup>28</sup> However, a hospital should ensure that the patient is aware that the transport team is from the receiving hospital and are not acting as the agents of the sending hospital in order to reduce potential apparent agency liability. Depending on the jurisdiction, even such knowledge on the part of a patient may not shield the hospital from liability.<sup>29</sup> The hospital may also retain independent duties to the patient, such as a duty to ensure the quality of its facilities or to supervise staff members who may continue to treat the patient along with the transport team.

Again, an interfacility transfer agreement may be helpful in such a situation. The agreement could establish which hospital will direct the care provided by the transport team and to spell out the duties each hospital assumes before and after the transfer. A state may even require specialty hospitals to maintain transfer agreements as a condition of licensure.<sup>30</sup>

## A Note about EMTALA

If the patient to be transferred is in an unstable condition and, under current federal regulations, is not an inpatient,<sup>31</sup> the Emergency Medical Treatment and Labor Act (EMTALA)<sup>32</sup> applies. EMTALA requires that the transfer be “appropriate” and sets forth specific duties of the sending and receiving hospital.<sup>33</sup> EMTALA’s non-discrimination provisions require specialty hospitals to accept appropriate transfers<sup>34</sup> and authorize receiving hospitals to sue sending hospitals for expenses if a transfer is inappropriate.<sup>35</sup> The law also requires hospitals to have on-call physicians to respond to emergencies as well as procedures to ensure the availability of emergency services if a particular on-call specialist is not available.<sup>36</sup>

EMTALA thus creates an independent basis of liability for hospitals if the transfer of an unstable patient is not “appropriate.”<sup>37</sup> Even when the sending hospital might have been found to have relinquished control of a patient and the treating physicians at the sending hospital no longer had a duty of care toward that patient, the hospital itself conceivably could be found to have violated its EMTALA duty to effectuate a medically appropriate transfer. The reach of EMTALA is limited by federal regulations, which confine the scope of the law to individuals not yet admitted as inpatients, but the courts are unsettled in the degree of deference to be accorded to the federal regulations in this regard. Therefore, it is important for interfacility transfer agreements to take into account the express EMTALA obligations incurred by covered hospitals in addition to identifying relative responsibilities in a medical negligence context.

Malpractice liability and liability under EMTALA are two different legal questions. If a patient is being transferred because the sending hospital is not capable of stabilizing the patient with the resources available there, the hospital presumably will have satisfied EMTALA’s requirements that it provide the medical treatment within its capacity and arrange for an appropriate transfer to stabilize the patient. However, the treating physicians and the sending hospital may retain legal responsibility for the patient until the transfer is complete, regardless of EMTALA.

## Conclusion

The law governing liability of physicians and hospitals for patient care in transfer situations varies widely based on state law and the individual circumstances of the case. Hospitals should use contracts to clarify relationships between providers and hospitals and the duties that attend those relationships. In particular, interfacility transfer agreements can help establish the terms of the transfer in order to clarify respective duties and methods for assuring the proper execution of those duties.

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<sup>1</sup> EMSC Performance Measures 76 and 77 address the number of hospitals in each state that have written pediatric interfacility transfer guidelines and agreements in place.

<sup>2</sup> Rand Rosenblatt, Sylvia Law, and Sara Rosenbaum, *Law and the American Health Care System* (Foundation Press, 1997; 2001-2002 Supplement). Ch. 1.

<sup>3</sup> 17 A.L.R.4th 132.

<sup>4</sup> Mead v. Legacy Health System, 220 P.3d 118, 126 (Or. App. 2009).

<sup>5</sup> Wheeler v. Yettie Kersting Mem’l Hosp., 866 S.W.2d 32, 40 (Tex. App. 1993).

<sup>6</sup> Rosenblatt et al., *Law and the American Health Care System*, Ch. 3 (and cases cited therein).

<sup>7</sup> Reynolds v. Decatur Mem’l Hosp., 660 N.E.2d 235, 236 (Ill. App. Ct. 1996).

<sup>8</sup> Mead v. Legacy Health System, 220 P.3d 118, 126 (Or. App. 2009) (“Although defendant’s on-call status in and of itself did not give rise to a physician-patient relationship with plaintiff, that status, combined with defendant’s advice that plaintiff was not a neurosurgical candidate and should be admitted for observation and pain management, constituted diagnosis and treatment and did constitute implied consent to a physician-patient relationship with plaintiff. Defendant’s on-call status and the attendant obligation to be available distinguish this case, which is limited to its facts, from the casual “curbside” consult that one physician may provide to another as a professional courtesy.”)

<sup>9</sup> Irvin v. Smith, 31 P.3d 934, 942-944 (Kan. 2001).

<sup>10</sup> Oja v. Kin, 581 N.W.2d 739, 743 (Mich. Ct. App. 1998); Prorise v. Foster, 544 S.E.2d 331, 333 (Va. 2001).

<sup>11</sup> McKinney v. Schlatter, 692 N.E.2d 1045, 1050 (Ohio App. 1997) (The court held that “a physician-patient relationship can exist by implication between an emergency room patient and an on-call physician who is consulted by the patient’s physician but who has never met, spoken with, or consulted the patient when the on-call physician (1) participates in the diagnosis of the patient’s condition, (2) participates in or prescribes a course of treatment for the patient, and (3) owes a duty to the hospital, staff or patient for whose benefit he is on call.”)

<sup>12</sup> Kelley v. Middle Tennessee Emergency Physicians, 133 S.W.3d 587, 596 (Tenn. 2004).

<sup>13</sup> Rosenblatt et al., *Law and the American Health Care System*, Ch. 1.

<sup>14</sup> Sterling v. Johns Hopkins Hosp., 802 A. 2d 440 (Md. Ct. Spec. App. 2002).

<sup>15</sup> EMRC is a referral service established by the Maryland Institute for Emergency Medical Services Systems (MIEMSS) to provide a coordinated transport system to reduce morbidity and mortality. 802 A.2d at 442, n. 3.

<sup>16</sup> Hopkins provided a “High-Risk Maternal Consultation/Referral Service” for patients in Maryland. 802 A.2d at 442, n. 4.

<sup>17</sup> MIEMSS protocol at the time dictated that pregnant women receiving magnesium sulfate could not be transferred by helicopter. 802 A.2d at 443, n. 5.

<sup>18</sup> Ms. Sterling’s baby was delivered via emergency caesarian section at Easton Memorial Hospital and she died at the University of Maryland Hospital. These hospitals were not implicated in the case. 802 A.2d at 443.

<sup>19</sup> 802 A.2d at 458-459.

<sup>20</sup> American College of Emergency Physicians. *Interfacility Transportation of the Critical Care Patient and Its Medical Direction*. 2005.

<sup>21</sup> See e.g., McKinney, 692 N.E.2d 1045 at 1050.

<sup>22-22</sup> E.g., Fridena v. Evans, 622 P.2d 463 (Ariz. 1980) (noting that traditionally hospital was merely a physical structure where physicians practiced, but that hospital now has duty to review medical services provided in hospital and to supervise quality of care and competence of staff); Grandillo v. Motesclaros (732 N.E.2d 863 (Ohio App. 2000) (hospital was not liable for physician’s alleged failure to obtain informed consent where physician was an independent contractor, not an employee).

<sup>23</sup> E.g., Lo v. Provena Covenant Med. Ctr., 796 N.E.2d 607 (App. Ct. 4th Dist. 2003).

<sup>24</sup> E.g., Thompson v. Nason Hosp., 591 A.2d 703 (Pa. 1991) (Under PA law, a hospital has a duty to: (1) use reasonable care in the maintenance of safe and adequate facilities and equipment; (2) select and retain only competent physicians; (3) oversee all persons who practice medicine within its walls as to patient care; and (4) formulate, adopt, and enforce adequate rules and policies to ensure quality care for the patients.); Campbell v. Hospital Service Dist. No. 1, Caldwell Parish, 768 So.2d 803 (La. Ct. App. 2d. Cir. 2000) (patient was entitled to rely on hospital’s expertise and independent professional judgment to assess doctor’s capabilities to handle emergency room duties).

<sup>25</sup> E.g., Simmons v. Tuomey Reg’l Med. Ctr., 533 S.E.2d 312, 322 (S.C. 2000) (“Given the fundamental shift in the role that a hospital plays in our health care system, the commercialization of American medicine, and the public perception of the unity of a hospital and its emergency room, we hold that a hospital owes a nondelegable duty to render competent service to its emergency room patients. [Our holding] is limited, however, to those situations in which a patient seeks services at the hospital as an institution, and is treated by a physician who reasonably appears to be a hospital employee.”); Martell v. St. Charles Hosp., 137 Misc. 2d 980, 523 N.Y.S.2d 342, 352 (N.Y. Sup. Ct. 1987) (suggesting New York would hold hospitals liable for the malpractice of independent emergency room physicians under the nondelegable duty doctrine).

<sup>26</sup> Paintsville Hospital Co. v. Rose, 683 S.W.2d 255 (Ky. 1985) (hospital that operates an emergency room open to the public can be held liable based on ostensible or apparent agency for actions of private non-employee physician who performed emergency room services according to hospital’s schedule). See also Espalin v. Children’s Medical Center of Dallas, 27 S.W.3d 675 (Tex. Ct. App. 2000); Butkiewicz v. Loyola Univ. Medical Center, 724 N.E.2d 1037 (Ill. App. Ct. 2000); Simmons v. Tuomey Reg’l Med. Ctr., 533 S.E.2d 312 (S.C. 2000).

<sup>27</sup> Bynum v. Magno, 125 F. Supp. 2d 1249 (D. Haw. 2000) (comparing states that require hospital to imply authority to states that may find apparent authority where hospital merely failed to inform patients of a lack of authority).

<sup>28</sup> Weldon v. Seminole Mun. Hosp., 709 P.2d 1058 (Okla. 1985) (hospital was not liable for treatment in emergency room by plaintiff’s private family physician where hospital had no control over plaintiff’s care and no duty to supervise plaintiff’s physician).

<sup>29</sup> Jackson v. Power, 743 P.2d 1376 (Alaska 1987).

<sup>30</sup> E.g., RCW 70.41.115 (Washington regulation requiring interfacility transfer agreement with general hospital in service area as a condition of licensure of specialty hospital).

<sup>31</sup> A strong note of caution here is that at least one federal court has held that federal regulations that terminate EMTALA stabilization duties at the point of inpatient admission are contrary to the plain text of the statute and thus do not deserve deferential treatment. *Moses v. Providence Hospital*, 561 F.3d 573 (6th Cir. 2009).

<sup>32</sup> 42 U.S.C. § 1395dd. Implementing regulations can be found at 42 CFR § 489.24 et seq.

<sup>33</sup> 42 C.F.R. 489.24(e) (defining “appropriate transfer”).

<sup>34</sup> 42 U.S.C. § 1395dd(g).

<sup>35</sup> 42 U.S.C. § 1395dd(d)(2)(B).

<sup>36</sup> 42 C.F.R. § 489.24(j).

<sup>37</sup> EMTALA defines an appropriate transfer as one: “(A) in which the transferring hospital provides the medical treatment within its capacity which minimizes the risks to the individual’s health . . . ; (B) in which the receiving facility— (i) has available space and qualified personnel for the treatment of the individual, and (ii) has agreed to accept transfer of the individual and to provide appropriate medical treatment; (C) in which the transferring hospital sends to the receiving facility all medical records (or copies thereof) related to the emergency condition . . . ; (D) in which the transfer is effected through qualified personnel and transportation equipment . . . ; and (E) which meets other requirements as the Secretary may find necessary in the interest of the health and safety of individuals transferred.” 42 U.S.C. § 1395dd(c)(2).