

## EMTALA: FOCUS ON CRITICAL CARE

**Disclaimer:** This information does not constitute legal advice, is general in nature, and because individual circumstances differ it should not be interpreted as legal advice. The speaker provides this information only for Continuing Medical Education purposes.

**Objectives:** After this presentation, participants will have the ability to: (1) understand important EMTALA case law, (2) know their major obligations under EMTALA, and (3) understand major rules from EMTALA regulations, and understand the difference between regulations and case law.

### THE GREAT CASES

1. Summers v. Baptist Med. Ctr., 69 F.3d 902 (8<sup>th</sup> Cir. 1995), *rehearing en banc*, 91 F.3d 1132 (8<sup>th</sup> Cir. 1996). The plaintiff fell from a tree stand while hunting. He went to the defendant hospital, where he received a discharge diagnosis of "muscle spasms." He went to another hospital two days later where they diagnosed bilateral hemopneumothoraces, multiple vertebral compression fractures, multiple rib fractures, and a sternal fracture.

The court defined an inappropriate screening exam as a disparate exam compared with similarly situated patients. This plaintiff merely alleged negligence.

2. Vickers v. Nash, 78 F.3d 139 (4<sup>th</sup> Cir. 1996). The patient came to the emergency department after a fight with a head injury and intoxication. The emergency physician stapled his head laceration, observed the patient for 11 hours, and discharged the patient. The patient died four days later from an epidural hematoma.

The court held that (1) the plaintiffs failed to allege the decedent received a disparate screening exam, and (2) hospitals must stabilize only those EMCs of which they are aware.

Also, see recent cases decided similarly: Fewins v. CHS, \_\_\_ F.Supp.2d \_\_\_, No. 3:14-cv-0898-M, (N.D. Tex. Jan 25, 2016) and Delibertis v. Pottstown Hospital, No. 14-6971, (E.D. Pa. Jan 21, 2016).

3. McIntyre v. Schick, 795 F.Supp. 777 (E.D. Va. 1992). The plaintiff came to the hospital in alleged labor. She never came through the ED, but went directly to L&D. She was discharged after 11½ hours, returned the next night, was then transferred

without proper certification, had a c-section, and the baby died a few days later. The hospital alleged EMTALA did not apply because the patient never "came to" to ED.

The court held that patients do not have to come through a hospital's ED to state a claim under EMTALA.

4. Sercye v. Ravenswood, 140 F.Supp.2d 944 (N.D. Ill. (2001) and Chicago Cir. Ct. A teenager sustained a gunshot wound to the abdomen. His friends carried him to the base of the defendant's ED ramp. The hospital had a policy prohibiting employees from going outside to help patients. Approximately 45 minutes later, police carried the patient into the ED where he died.

The case settled after the plaintiffs entered evidence into the record that the decedent's friends carried him to hospital property.

5. Johnson v. University of Chicago Hospitals, 982 F.2d 230 (7<sup>th</sup> Cir. 1993). The decedent, a one month old female, had a cardiac arrest five blocks from the defendant hospital. By telemetry, a nurse told EMS to take the patient to another hospital, as the hospital was on diversion. The patient died.

The court held the patient never "came to" the defendant hospital, therefore no EMTALA violation occurred.

6. Harry v. Marchant, 237 F.3d 1315 (11<sup>th</sup> Cir. 2001), *rehearing en banc*, 291 F.3d 767 (11<sup>th</sup> Cir. 2002). The plaintiff got admitted through the ED to rule out a pulmonary embolism. The hospital ran out of isotope for a V/Q scan. The patient laid in the ED all night, then went to the ICU early the next morning. The plaintiff alleged an EMTALA violation based on a failure to stabilize.

The court held the plaintiff failed to state a cause of action, because EMTALA mandates stabilization only if a transfer occurs.

7. Carlisle v. Frisbee, 888 A.2d 405 (N.H. 2005). The emergency physician examined a depressed, intoxicated, and suicidal patient who twice refused to see a psychiatrist. The ED called the police, who then arrested the patient for 14 hours. The plaintiff alleged a failure to stabilize.

The court held the hospital failed to stabilize this plaintiff prior to transfer to jail.

8. Green v. Touro Infirmary, 992 F.2d 537 (5<sup>th</sup> Cir. 1993). A patient died soon after discharge from the hospital's ED. The hospital instructed the patient to go to another hospital for further care. Two physicians signed an affidavit verifying the patient's stability at the time of discharge. The plaintiffs

produced no contrary evidence. The court held the defendant hospital did not violate EMTALA because the patient was stable at the time of discharge from the ED.

See also Brooker v. Desert Hospital, 947 F.2d 412 (9<sup>th</sup> Cir. 1991) where the court stated "[a] patient may be in critical condition, however, and still be "stabilized" under the terms of the Act."

For a very recent case, see also Delibertis v. Pottstown Hospital, No. 14-6971 (E.D. Pa. Jan 21, 2016). This patient was discharged from the emergency department with a TIA and returned three hours later with a CVA. The court held there was no EMTALA violation because he was stable at the time of discharge.

9. Smith v. Janes, 895 F.Supp. 875 (S.D. Miss. 1995). The decedent sustained severe burns when his car exploded. The defendant hospital transferred him to a distant burn center. He had respiratory difficulties en route requiring EMS to divert to a nearby hospital for intubation. The patient later died.

The court denied the hospital's motion for summary judgment because the plaintiffs stated a cause of action under EMTALA, as they alleged the hospital should have transferred the patient by helicopter.

10. Moses v. Providence Hospital and Med. Ctr., 561 F.3d 573 (6<sup>th</sup> Cir. 2009). The defendant hospital admitted the patient for psychotic and "threatening" behavior. A psychiatrist wrote a progress note accepting the patient on a psychiatric ward "if patient's insurance will accept criteria." The hospital then promptly discharged the patient and he murdered his wife. The court declared that EMTALA applies to inpatients, and invalidated the CMS Regulation stating otherwise. The US Supreme Court accepted briefs on the case but ultimately decided not to grant writs(not to hear the appeal).

No other circuit followed the holding in Moses. For a very recent example, see Sumner v. Summerlin Hospital, \_\_\_ F.Supp.2d. \_\_\_, No. 2:14-cv-02121-JAD-VCF, (D. Nev. Feb 1, 2016). This patient died after admission for chest pain. She died before the inpatient physician could perform a physical examination, but an inpatient work-up was already ordered. The court stated the general rule that EMTALA duties end upon admission, unless the patient was admitted in bad faith (with no intent to treat).

11. St. Anthony Hospital v. DHHS, 309 F.3d 680 (10<sup>th</sup> Cir. 2002). The patient suffered severe injuries from a MVC. A community hospital ED tried to transfer the patient to St. Anthony when they diagnosed spinal fractures and a possible aortic injury. The surgeon on-call at St. Anthony refused. The administrative law judge and the DHHD departmental appeals board levied a fine

against St. Anthony. St. Anthony appealed to the federal court of appeals.

The court held St. Anthony violated EMTALA because it refused to accept this unstable patient. St. Anthony had a duty under EMTALA to accept this patient because it had the capability and capacity to provide his care.

12. Correa v. Hospital San Francisco, 69 F.3d 1184 (1<sup>st</sup> Cir. 1995). The decedent came to the hospital ED with family members, complaining of chest pain. Upon registration, hospital employees learned she was a member of an HMO. The patient waited all afternoon in the waiting room, while other patients with minor problems later came and left the ED after receiving treatment. Finally, late in the afternoon, a family member took her to the HMO office where she suffered a cardiac arrest and died.

The court held the hospital violated EMTALA by delaying the patient's screening exam after learning about her insurance. The delay was so egregious that it effectively qualified as a refusal to treat.

13. Morin v. Eastern Maine Medical Center, 779 F.Supp.2d 166, (D. Maine 2011). A gravid woman, 16 weeks gestation, came to the emergency department at 4:30 a.m. on a Sunday, complaining of contractions. An ultrasound showed a dead fetus. The patient had an uneffaced and non-dilated cervix. The obstetrician diagnosed Braxton-Hicks contractions. The patient went home and later delivered a stillborn in her bathroom.

She sued the hospital, alleging an EMTALA violation for a failure to stabilize. The jury rendered a verdict for the plaintiff, awarding her \$50,000 in compensatory damages and \$150,000 in punitive damages. The hospital appealed, but settled with the plaintiff while the appeal was pending.

Discussion: How can a jury render a verdict for a plaintiff in a case where the physicians never diagnosed an emergency medical condition?

14. Cruz-Vazquez v. Mennonite General Hospital, 717 F.3d 63 (1<sup>st</sup> Cir. 2013). A patient came to the emergency department with painless third trimester vaginal bleeding. The emergency physician performed a pelvic exam and determined the cervix was not dilated. She phoned the patient's obstetrician who advised treatment with Brethine and Vistaril, discharge, and follow-up in his office the following morning.

At that time, the cervix was dilated to 7 cm with a breech delivery. She was transferred to another hospital for an emergency cesarian section. The baby died two days later.

The court would not dismiss the plaintiff's disparate MSE claim because the physician did not follow the hospital's "Gravid with Third Trimester Bleeding" protocol.

## OUTLINE

### I. DUTIES CREATED UNDER EMTALA (42 U.S.C. §1395dd)

#### A. Screening Examination

1. "[I]f any individual ... comes to the emergency department and a request is made on the individual's behalf for examination or treatment of an emergency medical condition, the hospital must provide for an appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition ... exists." 42 U.S.C. §1395dd(a)
2. "Appropriate medical screening examination:" not defined
3. "Emergency medical condition:" "[A]cute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in - (i) placing the health of the individual ... in serious jeopardy, (ii) serious impairment of bodily functions, or (iii) serious dysfunction of any bodily organ or part; or  
 (B) with respect to a pregnant woman who is having contractions - (i) that there is inadequate time to effect a safe transfer to another hospital before delivery, or (ii) that transfer may pose a threat to the health or safety of the woman or the unborn child." 42 U.S.C. §1395dd(e) (1)

#### B. Stabilization

1. Defined: "to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer." 42 U.S.C. §1395dd(e) (3)
2. The duty to stabilize arises when the screening exam reveals an emergency medical condition. (See Vickers v. Nash Gen. Hosp., 78 F.3d 139 (4th. Cir. 1996)).

3. Once stabilized, the hospital and physician have fulfilled their duties arising under EMTALA. See Green v. Touro Infirmary, 992 F.2d 537 (5th Cir. 1993), Delibertis v. Pottstown Hospital, \_\_\_, F.Supp.2d \_\_\_, No. 14-69-71 (E.D. Pa. Jan 21, 2016).
4. The duties are also fulfilled if the patient refuses further examination or transfer.

C. Transfer

1. EMTALA does not provide transfer regulations for stable patients. The transfer regulations apply only to unstable patients.
2. "Appropriate" transfers of unstable patients:
  - a. patient or family request
  - b. physician signs certification that benefits outweigh risks
  - c. the transfer is performed appropriately
    - (1) transferring hospital provides medical treatment within its capabilities
    - (2) the receiving facility has (1) available space and qualified personnel to treat the individual, and (2) has agreed to accept the transfer.
    - (3) the transferring hospital sends all medical records related to the emergency condition for which the individual presented, that were available at the time of transfer. This specifically includes all consents. The name of any on-call physician who refused or failed to appear must be included.
    - (4) qualified personnel and transportation equipment

D. Enforcement

1. CMS (the Center for Medicare and Medicaid Services, formerly HCFA) enforces EMTALA through the Office of the Inspector General (OIG) of the Department of HHS.
  - a. complaint-driven system
  - b. up to \$50,000 fine against the hospital and/or physician

- c. exclusion from Medicare (for gross, flagrant or repeated violations)
- 2. Since Sept. 1995, the receiving hospital may be fined or terminated for not reporting violations.
- 3. A violation occurs if a patient must be transferred due to the failure of a consultant to appear in a timely manner. The party liable for such a violation is the consultant who failed to appear.
- 4. Private civil actions may be brought against the hospital (not against the physician):
  - a. by patients (for harm suffered from violations of EMTALA)
  - b. by receiving hospitals (to recover expenses incurred from violation of EMTALA, i.e.: inappropriate transfer)
- E. Definitions
  - 1. Emergency medical condition (see § IA3 above)
  - 2. Participating hospital: a hospital that accepts Medicare funds
  - 3. Stabilize (see § IB1 above)
  - 4. Transfer (see § IC above)
- F. Preemption: EMTALA does not preempt state law, except if a state law directly conflicts with any provision of EMTALA.
- G. "Reverse dumping" provision (§ 1395dd(g)) : "A participating hospital that has specialized capabilities or facilities (such as burn units, shock-trauma units, neonatal intensive care units), or (with respect to rural areas) regional referral centers . . . shall not refuse to accept an appropriate transfer . . . if the hospital has the capacity to treat the patient."
- H. No delay in examination or treatment (§ 1395dd(h)) "A participating hospital may not delay provision of an appropriate medical screening examination . . . in order to inquire about the individual's method of payment or insurance status."
- I. Whistleblower protections (§ 1395dd (i)): "A participating hospital may not penalize or take adverse



action against a qualified medical person . . . because the person . . . refuses to authorize the transfer of an individual with an emergency medical condition that has not been stabilized or against any hospital employee because the employee reports a violation of a requirement of this section."

## II. ADMINISTRATIVE UPDATES OF EMTALA FROM HCFA/CMS

- A. Final Regulations: 42 C.F.R. § 489.24 (**1994**). These Regulations have the force of law, and describe how HCFA (later CMS) enforces the law. New information added by the Regulations included:
  1. DHHS may fine receiving hospital for not reporting known violations (DHHS later stated that such reports should be made within 72 hours)
  2. EMTALA may apply to hospitals that have no ED
  3. "comes to" means that individual has arrived on hospital property, including ambulances owned and operated by the hospital
  4. the hospital cannot delay a screening examination to inquire about financial status
- B. HCFA Interpretive Guidelines for State Operations Manual (guidelines for investigators) (**1995** and **1998**)
  1. expanded the following directives:
    - a. posting signs in ED regarding patient rights
    - b. maintaining transfer records and patient logs for 5 years, maintaining on-call lists
  2. required hospitals that have no EDs to develop written policies regarding the management of EMCs.
  3. provided definition of "appropriate medical screening examination" in 1998: ". . . reasonably calculated to determine whether an emergency medical condition exists."
  4. hospital owned off-site clinics must provide appropriate MSEs
  5. a bad clinical outcome does not define an inappropriate MSE
  6. "triage" ≠ MSE
  7. MSE may occur anywhere on hospital campus
  8. "prior authorization" from an insurer before a MSE is inappropriate
  9. the presence of an EMC is determined by the physician performing the MSE, not by a managed care organization or any other remote party

- C. HCFA/OIG Special Advisory Bulletin(Managed Care) (**1999**)
  - 1. dual staffing of EDs for managed care (MCO) and non-MCO patients not prohibited, but all patients must receive the same MSEs
  - 2. MCO authorization not appropriate until patient stable
  - 3. Advanced Beneficiary Notices (ABNs): these forms allow providers to bill patients for services not covered by Medicare. Delaying the MSE to secure patient signatures on ABN forms would violate EMTALA.
  - 4. repeated HCFA's stated position that inquiries about financial liability should not delay the MSE
  - 5. "voluntary withdrawal of treatment request:" the hospital may have liability if a patient deserts the ED before the MSE if the patient had to wait for an unreasonable period of time
  
- D. Outpatient PPS Regulations (**2000**) (amended the EMTALA Regulations). Revised the definition of "comes to:"
  - 1. includes off-campus facilities (satellite clinics)
  - 2. includes the hospital driveway, sidewalk, and parking lots
  - 3. includes all hospital buildings within a 250 yard radius of the hospital's main building (42 C.F.R. § 413.65(a))
  
- E. November 13, **2003** EMTALA Regulation Amendments
  - 1. **Dedicated Emergency Department (DED):** A hospital must provide an appropriate MSE to all persons presenting to a DED, whether on or off campus. A facility qualifies as a DED if (1) it is licensed by a state as an ED, or (2) it holds itself out to the public as providing emergency care, or (3) during the preceding year, one-third of outpatient visits were for EMCs.
    - a. Other locations on-campus: individuals must receive an appropriate MSE if they request an exam and they indeed have an EMC (e.g.: visitors who develop an EMC).
      - (1) "Campus" includes the hospital, driveway, sidewalk, parking lots, and the "250 yard radius" rule as declared in the 2000 Regulations.
    - b. Off-campus: EMTALA does not apply, unless the facility meets the definition of a DED.

2. **Inpatients:** A hospital fulfills its duties under EMTALA when it screens a patient, detects an emergency medical condition, and admits the patient in good faith.
  3. If an individual comes to a hospital without an EMC, then no obligation exists beyond an appropriate MSE.
  4. **Scheduled outpatient appointments:** If a patient develops an EMC during such a visit, EMTALA does not apply, as Medicare Conditions-of-Participation already protect such patients.
  5. **Hospital-owned ambulances:** EMTALA not triggered when the patient enters the ambulance if the ambulance functions as part of a community-wide EMS system (i.e.: this negates the old Regulation which stated that patients entered the ED when they entered such an ambulance).
    - a. "Ambulance" now specifically includes air ambulances.
  6. **Managed Care:** Former HCFA notices on managed care organizations (MCOs) are now codified as Regulations. Specifically, an ED should not delay providing an appropriate MSE to (1) inquire about insurance, or (2) obtain authorization from a MCO.
  7. **On-call obligations:**
    - a. Physicians may provide coverage simultaneously at several hospitals
    - b. A physician may schedule elective surgery while on call.
    - c. Sometimes a specialty may not be available, and hospital may transfer the patient.
    - d. no rule regarding the ratio of specialists to the frequency of coverage
    - e. hospitals must have reasonable coverage
  8. CMS will not levy EMTALA sanctions during a national emergency.
- F. 2007 IPPS Final Rule (from EMTALA TAG recommendations)
1. The hospital may designate who can certify a woman is in labor. Previously, this could only be done by a physician.

2. The Final Rule emphasizes the duty of hospitals with specialized capabilities to accept appropriate transfers. This even applies to specialty hospitals without emergency departments.

G. Summary of Currently Applicable Administrative Updates (Regulations in **bold**)

1. DHHS may fine receiving hospitals if they do not report known violations within 72 hours. **(1994)**
2. EMTALA may apply to hospitals that have no ED **(1994)**
3. "Comes to" means that patient has arrived on hospital property. **(1994)**
4. mandatory posting of signs in ED (1995, 1998)
5. maintaining ED logs and transfer records for 5 years (1995, 1998)
6. hospitals without EDs must develop written policies dealing with the management of EMCs (1995, 1998)
7. definition of appropriate MSE (1998)
8. bad clinical outcome ≠ inappropriate MSE (1998)
9. triage ≠ MSE (1998)
10. MSE may occur anywhere on the hospital campus (1998)
11. "hospital" includes the driveway, sidewalk and parking lots **(2000, 2003)**
12. Definition of Dedicated Emergency Department **(2003)**
13. EMTALA does not apply to inpatient or to scheduled outpatient appointments **(2003)**.
14. EMTALA does not apply to hospital-owned ambulances if they function as part of a community-wide EMS system **(2003)**.
15. cannot alter MSE or stabilization for MCO patients **(2003)**.
16. on-call obligations **(2003)**.
17. no EMTALA sanctions during a national emergency **(2003)**

H. CMS INTERPRETIVE GUIDELINES FOR STATE OPERATIONS MANUAL (Mar. 21, 2008). New clarifications listed:

1. A physician may violate EMTALA if he repeatedly directs patient transfers to another hospital where he can more conveniently treat the patient.
2. Physicians may violate EMTALA when they refuse to participate on a hospital on-call list, but respond to calls on selective patients.

3. Physicians receiving reimbursement for on-call services cannot simultaneously be on-call at any other facility.
4. If a hospital allows on-call physicians to perform elective surgery, it must have a written back-up plan.
5. The interpretive guidelines repeat the HCFA definition of an appropriate medical screening examination: an exam reasonably calculated to determine whether an EMC exists.
6. An infant born in the ED or elsewhere in the hospital must receive an appropriate MSE.
7. A minor can request a MSE. Do not delay for parental consent.
8. Do not move patients to an office for a MSE. Offices are not subject to EMTALA.
9. **Hospitals that "park" EMS patients violate EMTALA regulations.** Exceptions exist when the physicians cannot leave the bedside of a critically ill patient.
10. If patients leave the ED by AMA or LWBS (desertion) this alone does not constitute a violation.
11. EMTALA does not apply to inpatients unless the hospital did not admit the patient in good faith.
12. If a patient uses a DED for nonemergent reasons, then the hospital may simply perform a MSE to determine that an EMC does not exist. No EMTALA obligations exist beyond that point.
13. No obligation exists under EMTALA to provide preventive care (e.g.: routine immunizations) or to collect forensic data.
14. Regarding "medical clearance" after arrest or incarceration, the MSE may be limited to the determination of whether an EMC exists.
15. An inappropriate discharge of an inpatient may violate Medicare Conditions of Participation, but does not violate EMTALA.
16. If a patient refuses care, the medical record should reflect (1) the nature of the treatment offered, (2) risks and benefits of the care, and (3) steps taken to obtain a written refusal when the patient deserts.
17. Hospitals must not coerce patients by telling them they must pay for treatment if they stay, but will receive free care if they agree to a transfer.
18. A receiving hospital may delay the transfer of a stable patient to inquire about insurance status.

19. The "appropriate transfer" rules apply to a case where the patient is sent to another hospital for a diagnostic test with the anticipation of a return. These rules do not apply to the return trip.
20. A receiving hospital has no duty to accept a lateral transfer (i.e.: not transferred to a higher level of care).

III. MAJOR CONTROVERSIES FROM CASE LAW (Note, you may find case law, statutes, and Regulations most conveniently from the following three websites: lawsources.com/also, findlaw.com, and law.cornell.edu .)

A. "Appropriate Medical Screening Examination"

1. The Comparability/Disparity Test: Now the only test used by federal circuit courts: The plaintiff must prove that he received a disparate screening exam compared to similarly situated patients. Summers v. Baptist Medical Center, 91 F.3d 1132 (8th Cir. 1996). Patients must receive a screening exam and treatment appropriate to their actual diagnosis (as determined by the screening exam), not their real diagnosis (the patient's real problem.) Vickers v. Nash Gen. Hosp., 78 F.3d 139 (4th Cir. 1996). Hospitals must have policy describing approp. MSE.  
Jackson v. East Bay Hosp., 246 F.3d 1248, (9th Cir. 2001). The Ninth Circuit adopted the comparability test. Significant because HCFA definition not adopted.
2. The Bad Motive Test: Overruled by the U.S. Supreme Court in Roberts v. Galen, 525 U.S. 249, 119 S. Ct. 685 (1999).
3. The Capability/Negligence Test: A negligence-based test only briefly adopted by the 4th Circuit. No longer followed.
4. Denial of Screening Exam: A psychiatric patient deserted from the emergency department (refused examination). The patient later alleged an EMTALA violation for failure to provide a MSE. The court held it could not dismiss the claims and they had

to be heard by a jury. Lee v. Hennepin County, No. 0:13-cv-01328-PJS-HB (D. Minn. 2013).

B. Hospital EMTALA Policies

1. Cruz-Vazquez v. Mennonite General Hospital, 717 F.3d 63 (1<sup>st</sup> Cir. 2013). A patient with third trimester bleeding was discharged from the emergency department. The physician did not follow all the directives in a hospital policy. Therefore, the court concluded this provided evidence of a disparate examination.
2. Hoffmann v. Tonnemacher, 425 F. Supp.2d 1120 (E.D. Cal. 2006). A hospital may have liability under EMTALA if it did not follow its own policy on appropriate screening examinations. Hospital policy required emergency physicians to address every item in the differential diagnosis. However, in a later motion for summary judgment, the court held the plaintiff could not show causation, as the results of a blood culture (recommended by the plaintiff's expert to rule out sepsis) would not have been available for two days, and the patient was stable for discharge. No. CIV F 04-5714 AWI DLB (E.D. Cal. Apr. 10, 2008).
3. Cruz-Quiepo v. Hospital Español Auxilio Mutuo de Puerto Rico, 417 F.3d 67 (1<sup>st</sup> Cir. 2005). Mistriage may violate EMTALA if it violated a hospital policy. The patient alleged he complained of chest pain although two physicians documented he only complained of left upper extremity pain. The court reversed a motion for summary judgment for the hospital.

C. Does EMTALA Apply to Inpatients? A controversy existed prior to the 2003 amendments to the Regulations. Some cases since the 2003 amendments:

1. Morgan v. N. Mississippi Medical Center, 403 F.Supp.2d 1115 (S.D. Ala. 2005). A hospital may have liability for failure to stabilize an admitted patient, if it admitted the patient merely as a subterfuge to avoid liability.

2. Preston v. Meriter Hospital, 700 N.W.2d 158 (Wis. 2005). The Court held that the plaintiffs stated a claim for damages based on their allegation that their newborn child did not receive a screening exam while he was born in the birthing center.

The dissent stated that the baby was an inpatient. Three concurring justices stated that the parties should brief this issue in the trial court.

3. Lima-Rivera v. UHS of Puerto Rico, Inc., 476 F.Supp.2d 92( D.P.R. 2007). After birth in the defendant's labor and delivery room, the baby went to the nursery, and then the critical care nursery. The following day he was transferred to another hospital after vomiting blood. He died soon after arrival at the receiving hospital. The court held the baby "came to" the hospital at birth. The court ignored the 2003 CMS Regulations stating that EMTALA did not apply to inpatients. The court refused to dismiss the plaintiffs' claims on summary judgment.
4. Moses v. Providence Hospital and Med. Ctr., 561 F.3d 573 (6<sup>th</sup> Cir. 2009). The defendant hospital admitted the patient for psychotic and "threatening" behavior. A psychiatrist wrote a progress note accepting the patient on a psychiatric ward "if [patient]'s insurance will accept criteria." The hospital then promptly discharged the patient and he murdered his wife. The court declared that EMTALA applies to inpatients, and invalidated the CMS Regulation stating otherwise.

D. Liability for delays in treatment

1. Correa v. Hospital San Francisco, 69 F.3d 1184 (1st Cir. 1995) If the court determines that the financial interview delayed the screening exam, it will probably hold the hospital in violation of EMTALA. This case involved an HMO. Delay of screening exam to satisfy managed care procedures will probably violate EMTALA.
2. Parker v. Salina Regional Health Center, Inc., 463 F.Supp.2d 1263 (D.Kans. 2006). A patient had a cardiac arrest 20 minutes after arriving in the E.D. waiting room. The clerk merely asked about



insurance just prior to the patient's cardiac arrest. The court dismissed the plaintiff's claims on summary judgment.

3. In re: St. Joseph's Medical Center, (DHHS ALJ 2009). On Feb. 17, 2009, a DHHS administrative law judge levied a \$50,000 fine against a Stockton, CA hospital for failing to provide a medical screening examination to an 88 year old man complaining of chest pain. He waited "for nearly three hours" then died in the waiting room.

#### E. Failure to Stabilize

1. Harry v. Marchant, 237 F.3d 1315 (11th Cir. 2001) A hospital may violate the stabilization requirement even if it admits a patient through the ED. In this case, the "failure to stabilize" claim was based on (1) lack of availability of isotope for V/Q scan, and (2) seven hour delay in admission. (Reversal of 12(b)(6) dismissal.)  
However, the 11<sup>th</sup> Circuit reheard this case en banc (a panel of nine judges) and reversed the previous decision. 291 F. 3d 767 (2002). In a case of first impression, the Court stated that the duty of stabilization under EMTALA only arises in cases where a transfer occurs. Otherwise, an allegation of improper stabilization is really an allegation of negligence.
2. Carlisle v. Frisbie Memorial Hospital, 888 A.2d 405 (N.H. 2005). The defendant had liability for failure to stabilize when the emergency physician had the police arrest a psychiatric patient after performance of the screening exam.
3. Morin v. Eastern Maine Medical Center, \_\_\_\_ F.Supp.2d \_\_\_\_, No. CV-09-258 (July 28, 2010; Mar 25, 2011; Aug 22, 2011) (E.D. Maine 2011). A gravid woman, 16 weeks gestation, came to the emergency department at 4:30 a.m. on a Sunday, complaining of contractions. An ultrasound showed a dead fetus. The patient had an uneffaced and non-dilated cervix. The obstetrician diagnosed Braxton-Hicks contractions. The patient went home and later delivered a stillborn in her bathroom. She sued the hospital, alleging an EMTALA

violation for a failure to stabilize. The jury rendered a verdict for the plaintiff, awarding her \$50,000 in compensatory damages and \$150,000 in punitive damages. The hospital appealed, but settled with the plaintiff while the appeal was pending. Discussion: How can a jury render a verdict for a plaintiff in a case where the physicians never diagnosed an emergency medical condition?

F. Method of Transport

1. Smith v. Janes, 895 F. Supp. 875 (S.D. Miss. 1995) Using an inappropriate vehicle may violate EMTALA. (A burn patient had a respiratory arrest while transported by ground. The court said the patient should have been transported by air).

G. Liability for ambulance diversion

1. Johnson v. Univ. of Chicago Hosps., 982 F.2d 230 (7th Cir. 1993). The leading case. A hospital may direct an ambulance by radio to another facility when on diversion (when they lack to capacity to care for the patient).
2. Arrington v. Wong, 237 F.3d 1066 (9th Cir. 2001). The hospital violated EMTALA when it had the capacity to care for a patient, but diverted an ambulance by radio to another hospital. "Comes to" also means "comes toward." (Holding: A hospital may divert only when on "diversionary status.")
3. Morales v. Sociedad Española et al., 524 F.3d 54 (1<sup>st</sup> Cir. 2008). An ambulance notified the ED of the impending arrival of a young woman with severe abdominal pain, previously diagnosed with an ectopic pregnancy. The emergency physician inquired about the patient's insurance. When EMS did not verify her insurance, the physician abruptly terminated the call. EMS took the patient to another hospital. The court reversed the summary judgment for the hospital, citing Arrington.

H. Enforcement of the "reverse dumping" provision  
(Subsection (g))

1. Miller v. Med. Ctr. of SW La., 22 F.3d 626 (5th Cir. 1994). A regional referral center turned down a transfer for financial reasons. The court would not apply subsection (g) as the patient never "came to" the defendant hospital (the court read the statute disjunctively).
2. St. Anthony Hospital v. U.S. Dep't H.H.S., 309 F.3d 680 (10<sup>th</sup> Cir. 2002) If a referral center has the capability and capacity to treat an appropriately transferred patient, then it must agree to accept the patient in transfer.

I. WHISTLE BLOWER PROTECTION

1. The plaintiff, an employee of the hospital for 38 years, was terminated two months after filing an EMTALA complaint against her hospital. The court refused to dismiss her complaint, sending it to a jury trial. The opinion provided a detailed analysis of how a court evaluated a retaliation claim against a hospital after terminating an EMTALA whistle blower. O'Connor v. Jordan Hospital, \_\_\_ F.Supp.2d \_\_\_, No. 10-1416-MBB (D. Mass. 2013).

J. Billing Practices

1. Plaintiffs around the country filed a flurry of class action suits in 2005-2006 alleging that charitable hospitals violated EMTALA by pursuing aggressive bill collection practices against uninsured patients. Courts uniformly dismissed these actions as plaintiffs did not plead damages compensable as "personal injuries." See e.g.: Kizzire v. Baptist Health System, 441 F.3d 1306 (11<sup>th</sup> Cir. 2006).
2. Harrison v. Christus St. Patrick Hospital, 430 F.Supp.2d 591 (W.D. La. 2006). The plaintiff alleged that the defendant hospital violated EMTALA by (1) requiring her to sign a guarantee of payment prior to admission to the emergency department, and (2) charging uninsured patients more than discounted Medicare and Medicaid rates.

The court dismissed all of the plaintiff's claims. This plaintiff never paid her bill and suffered no damages.

K. State Law Issues

1. Coleman v. Deno, 813 So. 2d 303 (La. 2002).  
Patient "dumping" does not constitute an intentional tort. The failure to treat is a form of negligence.
2. Sterling v. Johns Hopkins, 802 A.2d 440 (Md. Ct. App. 2002). This case did not deal with an EMTALA claim, but contained a long discussion of patient transfer procedures. The Court concluded that referring physicians have primary responsibility for the transfer.

IV. AVOIDING VIOLATIONS: HOW TO COPE WITH EMTALA

- A. provide non-disparate screening exams to all patients
- B. don't delay screening exam to ask about insurance
- C. don't delay screening exams on HMO patients, or treat them differently
- D. regional referral centers must accept appropriate transfers
- E. beware of unstable transfers
- F. proper certification and documentation of transfers
- G. provide appropriate personnel and equipment during transfers
- H. hospitals ownership of ambulances increases its liability exposure if not part of a community-wide EMS program.

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Cruz-Vazquez v. Mennonite General Hospital, 717 F.3d 63 (1<sup>st</sup> Cir. 2013). Failure of a physician to adhere to a relevant hospital policy creates the presumption of a disparate medical screening examination.

Delibertis v. Pottstown Hospital, \_\_\_ F.Supp.2d \_\_\_, No. 14-6971, (E.D. Pa. Jan 21, 2016). Patients has been stabilized under EMTALA if they are stable at the moment of discharge.

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# EMTALA: FOCUS ON CRITICAL CARE



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## OBJECTIVES

- case law review
- obligations
- focus on transfers



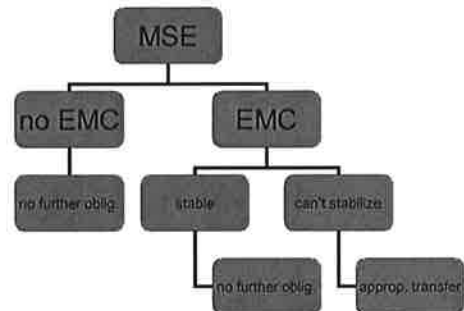
## DUTIES

Created by EMTALA

- screening exam
- stabilization
- approp transfer



## OBLIGATIONS



## VICKERS v. NASH

78 F.3d 139 (4th Cir. 1996)




## VICKERS v. NASH

78 F.3d 139 (4th Cir. 1996)


- 12(b)(6) dismissal
- Holdings:
  - $\Pi$  did not allege disparity
  - no duty to stabilize







### GREEN v. TOURO

992 F.2d 537 (5<sup>th</sup> Cir. 1993)









### GREEN v. TOURO

992 F.2d 537 (5<sup>th</sup> Cir. 1993)




- no insurance
- renal failure
- D/C, no transportation
- died before arrival at other hosp




### GREEN v. TOURO

992 F.2d 537 (5<sup>th</sup> Cir. 1993)



- holding: stable at D/C
- **Brooker v. Desert Hosp**
  - 947 F.2d 412 (9<sup>th</sup> Cir 1991)
- **Delibertis v. Pottstown Hosp**
  - No. 14-6971(ED Pa. Jan 21, 2016)




### TRANSFER

Unstable Patients




- pt or family request
- certification
- appropriate transfer







### APPROP TRANSFER

Unstable Patients




- max treatment
- receiving facility
  - (1) has space and personnel
  - (2) accepts transfer







### APPROP TRANSFER

Continued




- medical records
- qualified personnel and eqpt.
- duty to report violations








### SMITH v. JANES

895 F.Supp. 875 (S.D. Miss. 1995)








### SMITH v. JANES

895 F.Supp. 875 (S.D. Miss. 1995)



- MSJ dismissal denied
- Holdings:
  - no ROA v. physician
  - approp MSE (comp.)
  - stabilized?
  - transport by air







### MISC PROVISIONS




- "reverse dumping"
- delays in treatment
- whistleblower protection








### ST ANTHONY v. DHHS

309 F.3d 680 (10<sup>th</sup> Cir. 2002)











### ST ANTHONY v. DHHS

309 F.3d 680 (10<sup>th</sup> Cir. 2002)




- appeal of fine (hospital)
- Holdings:
  - Δ violated "reverse dumping"
  - on call MD = agent of hospital









### STERLING v. JOHNS HOPKINS


802 A.2d 440 (Md. Ct. App. 2002)








 **STERLING v. JOHNS HOPKINS**   
802 A.2d 440 (Md. Ct. App. 2002)



- deterioration en route
- primary responsibility




 **2003 REGULATIONS** 



- definition of DED
- inpatients and clinic visits
- hosp-owned ambulances




 **2003 REGULATIONS**   
(continued)



- managed care
- on-call physicians
- national disasters




 **ON-CALL OBLIGATIONS**   
(2003)



- MD on-call at >1 hospital
- elective surgeries
- unavailability
- ratio




 **AVOIDING VIOLATIONS** 

- non-disparate exams
- don't delay
- regional referral centers
- beware of unstable transfers



 **AVOIDING VIOLATIONS**   
Continued

- proper certification
- approp personnel and eqpt
- hosp ambulances (incr. liab.) \*
- near hosp. property \*





## TAKE HOME POINTS



- EMTALA fulfilled when pt stable
- must accept approp transfer
  - outpt; max rx; avail bed/personnel; rec'ds; transport
- interventions=responsibility



## QUESTIONS

