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Emergency Medicine Malpractice Case Reporter

Overview

Whether patients are seen in an office or in the emergency department (ED), the risk of missing an ectopic pregnancy is significant. Even with diagnostic and technological advancements, ectopic pregnancy is missed 50% of the time at the first office visit and 36% of the time at the first ED visit. The high rate of missed ectopic pregnancy underscores the point that this diagnosis must be considered in all women of childbearing age with symptoms that may be related to pregnancy—ectopic or otherwise. Failure to consider this diagnosis at the time of the first visit is a common mistake. Research demonstrates that delayed diagnosis leads to increased morbidity and mortality.

The sensitivity of urine pregnancy testing, protocols for automatic pregnancy testing in women of childbearing years and the ability to obtain pelvic ultrasound with relative ease has resulted in a reduction in medical errors and patient injury in this important area. The profile of cases resulting in adverse outcomes is changing.

A recent review of 2001 claims by a large national malpractice insurer demonstrates several areas of concern, including:

1. Compliance with emergency department protocols regarding mandatory urine pregnancy testing in women of childbearing years. In particular, problems arise when the patient history includes a recent normal period; sexual abstinence; a history of a tubal ligation; or a recent D & C. The cases suggest that these historical items result in a failure to obtain urine pregnancy testing and a missed or delayed diagnosis of ectopic pregnancy.

2. Methotrexate therapy is being utilized more frequently for the management of ectopic pregnancy. Emergency practitioners must be aware that the drug may have been used and the problems or complications and special issues related to methotrexate that may result. This subject is dealt with extensively in the TSG computer based course "Ectopic Pregnancy: Medical Error and Risk Reduction." The course can be accessed through the TSG home page at www.thesullivangroup.com.

3. The 2001 claims introduce a second important methotrexate issue. Claims are beginning to demonstrate that in some cases methotrexate is being administered for treatment of ectopic pregnancy without diagnostic evidence of ectopic pregnancy on ultrasound. In general, methotrexate is administered when there is ultrasound evidence of an ectopic pregnancy. In these cases, methotrexate is administered when there is a presumed ectopic pregnancy. As a result, malpractice claims are being filed for the inadvertent administration of methotrexate to patients with intrauterine pregnancy.

Case Review

Subject: Pregnancy Testing in Women of Childbearing Years

The patient was a 23-year-old female who presented to the emergency department on a Tuesday morning at 8:30 AM with right lower quadrant abdominal pain and constipation. She stated that she had taken an enema and Dulcolax the night before and still had not had a bowel movement. No vomiting or diarrhea. Review of systems otherwise negative. Past medical history revealed that she had a D & C performed by her obstetrician one-month prior, following an episode of heavy vaginal bleeding and a positive pregnancy test. That had been her first pregnancy. Her last menstrual period ended four days prior to this visit, although it had been lighter than usual. The emergency physician and nurse both asked the patient if she was pregnant, and she answered no to both. There was no complaint of vaginal bleeding or discharge.

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Triage vital signs revealed a blood pressure of 110/60, respirations 20, pulse 72, and she was afebrile. On physical examination the patient had mild lower abdominal discomfort, without guarding or rebound. Bowel sounds were normal. Heart and lung exams were normal. Flanks non-tender. Extremities normal. No other examination documented.

The physician ordered four views of the abdomen and a CBC. The white blood cell count was normal. The hemoglobin and hematocrit were 11.4 and 33 respectively. The plain films of the abdomen revealed a non-specific gas pattern. Chest film was normal. Prior to the x-ray abdomen, the radiology staff was required to fill in a form regarding pregnancy. On the form, the question "Is the patient pregnant?" was answered "No."

The patient was discharged to home at approximately 10:30 AM with a diagnosis of "Constipation." The physician prescribed Colace and Magnesium Citrate. She was to return within 2 days if she was not better or her condition worsened.

That evening she felt better and went out to dinner with her husband. She did not eat much for dinner and by later that evening she still had not had a bowel movement. At approximately 10:00 PM the abdominal pain increased and later became severe. According to the husband the patient became very pale and began sweating. He called back to the emergency department and explained to the individual answering the phone that his wife had "severe constipation" and that they had been in the ER earlier and that his wife was cold, sweating and was in severe pain.

He testified in his deposition that he assumed the person on the telephone was a nurse. He further testified that he was told that the physician had already prescribed a laxative and that it needed an opportunity to work. Also, that anything she took for pain might interfere with the action of the laxative. He testified that he did not know the person's name and could not describe her voice.

The patient then dozed off, and by midnight the husband was unable to wake her. He called 911. The ambulance arrived within minutes and the paramedics began resuscitative efforts. The husband and paramedics testified that they were able to obtain a heartbeat at some point but then lost it. The ambulance took her to the closest hospital where resuscitation continued. By that time she was in full cardiac arrest. The pregnancy test was positive and she was taken to the operating room for a hemorrhage from a presumed ruptured ectopic pregnancy.

Despite surgery the patient's condition declined and she was made a DNR and expired on the following day. The final diagnosis was "ruptured ectopic pregnancy." The death certificate lists the immediate cause of death as "cerebral anoxia as a consequence of blood loss due to ruptured ectopic pregnancy." The case was settled for $600,000 on behalf of the surviving spouse.

Discussion

There are several critical issues in this case:

1. **Pregnancy Testing Policy**. The ED had a policy for obtaining urine pregnancy testing in all cases of women of childbearing years with abdominal complaints. This policy was not followed. The fact is that obtaining a pregnancy test on this woman was probably the standard of care. The fact that there is a department policy on the subject would make the case nearly impossible to defend.

2. **Physician and Nursing Exposure.** The malpractice exposure almost certainly involves both the physician and nursing practitioners in this type of case. Both breached standards of care, and violated department protocol.

3. **Key Issue.** The physician erred in relying on the history of the D & C, the recent "menstrual period," and the patient asserting that she was not pregnant. The recent D & C is a common theme in recent failure to diagnose ectopic pregnancy cases. The common fact pattern is that the D & C is accomplished, and all parties believe that the pregnancy has been terminated. However, without microscopic evidence from pathology that the tissue removed was fetus and placenta, the pregnancy may not have been terminated, and an ectopic pregnancy remains.

4. **ED Call Backs**. Testimony suggests that there was a telephone call for help from the husband, which was poorly handled by the emergency department staff. There was no documentation of the phone call, or of any advice given by the staff to the husband. No one working that evening had an independent recollection of this telephone conversation. It is common in malpractice claims in emergency medicine that there is testimony from family of calls back to the emergency department for help. The emergency department should have a rock solid policy on call backs. They should be funneled to the physician or charge nurse. Staff should document every call. Implementation of a recording system for call backs may be prudent. Staff should err well on the side of caution when a patient calls in for an apparent change in condition. Assuming that this call was made as claimed, the change in condition should have resulted in a call to 911. ♦

For more information about the failure to diagnose Ectopic Pregnancy and other High Risk Emergency Department clinical entities, see the Core Curriculum on Risk and Error Reduction in Emergency Medicine on the TSG home page at www.thesullivangroup.com.

Special Issue

Intentional Torts In The Emergency Department: Assault & Battery

What is an Intentional Tort?

The legal dictionary provides a basis for understanding what a tort is. A tort is "A private or civil wrong or injury…. for which the court will provide a remedy in the form of an action for damages." An intentional tort is "a tort in which the actor is expressly or impliedly judged to have possessed intent or purpose to injure".[i] Common intentional torts are assault, battery, false imprisonment, and defamation. Although physicians are knowledgeable about the law of medical malpractice, it is wise to have an understanding about other aspects of the law that may affect your personal and professional lives. For example, it is important to know that any liability resulting from a settlement or judgment related to an intentional tort is not covered under the physician's medical malpractice insurance policy.

This presentation addresses the intentional torts of assault and battery.

Assault

Assault is an action where the actor has the intent to batter, hit, strike, or wrongfully touch a victim. In addition the actor must actually have the ability to cause harm to a victim. Intent to harm, ability to harm, and the victim's knowledge that they could be harmed are the three necessary elements to the intentional tort of assault.[ii] An assault charge may be civil or criminal.

> An assault may be committed without actually touching, or striking, or doing bodily harm to someone else. If the intent and ability of the actor are known and feared, then the victim has been assaulted. In cases of medical assault this is often looked at as the actor must have a known disregard for the patient's well being.

An example of a case where a Pennsylvania trial court defined the factors that are necessary for an assault charge to be enforced is Commonwealth v. Byers.[iii] The Commonwealth of Pennsylvania charged five physicians with simple assault and other crimes for stapling patients without having administered anesthesia. All of the patients were inmates at the Polk Center, which treats severely to profoundly mentally retarded and developmentally disabled individuals.

The state presented to the court legally sufficient facts to support the charge of assault:

1) the closing of wounds by stapling without anesthesia was a "gross deviation from the accepted standard"
2) that such stapling "caused bodily injury to the victims."

The Court found that the defendant doctors asserted a valid defense under the Pennsylvania statute which states that "the court shall dismiss a prosecution if it finds that the conduct of the defendant did not actually cause or threaten the harm or evil sought to be prevented by the law defining the offense or did so only to an extent too trivial to warrant the condemnation of the conviction…"

The Court dismissed the simple assault charges. The Court based their finding on 3 facts:

1) that no evidence showed that any of the defendants had acted with an intent to hurt their patients
2) that defendants had "believed and intended that their actions would help heal the patients and not harm them more,
3) that, in some instances, the risks of administering anesthesia outweigh the risks of stapling a laceration without anesthesia.

Recall that one of the elements of the tort is "intent to harm." Since intent to harm was not present, the Court dismissed the case.

Battery

Battery occurs when an intentional and wrongful physical contact with a person takes place without his or her consent. The contact must cause some injury or offense.[iv]

When a court considers the question of whether a Medical battery occurred the two factors that are generally focused upon are[v]:

1. Was the patient aware that the doctor was going to perform the procedure in question? and if so,
2. Did the plaintiff authorize performance of such procedure?

An example of an occasion where the court found that the charges against the physician were legally sufficient to allege medical battery is found in Julie Zabensky v. Lawrence & Memorial Hospital et al..[vii]

> The Plaintiff entered defendant's emergency department requesting treatment for her injured foot. The Defendant instructed a nurse to withdraw blood from the patient. Plaintiff did not knowingly consent or give any informed consent to have the blood drawn. The Defendant then proceeded to disclose the results of Plaintiff's blood test to the Connecticut Department of Motor Vehicles (DMV); Plaintiff was subsequently required to submit to physical and mental examinations under the requests of the DMV in order to retain her driver's license. The hospital that the Defendant worked for sent the Plaintiff a bill for the treatment rendered to her foot and for the blood test.

The court held that "battery is a basis for recovery against a physician under circumstances where the physician fails to obtain consent to the particular treatment or performs a procedure different from the one for which consent has been given, or where he realizes that the patient does not understand what the operation entails." [vii] The plaintiff in the present case alleges that the defendants injected a needle into her body without her consent. This appears to be a clear-cut case of battery.

Physicians need to be aware of the legal limitations of consent. Physicians need to be aware of exactly what consent has been given and what they are being asked to do. The issue is not what the physician or the police want to accomplish. Orders for blood tests that are done on a routine basis for medical problems are probably covered by the general consent to treatment. Routine blood testing is a public expectation. However, when invasive testing goes beyond that public expectation, the best protection from allegations of assault is informed consent. Whatever form that consent happens to take in your institution is the consent procedure that should be followed. ♦

Endnotes

[i] See Black's Law Dictionary, 811 (6th ed. West 1990).
[ii] Id. at 114.
[iii] See Commonwealth v. Byers, Pa. C.P., Venango county, Dec. 16, 1999.
[iv] See Black's Law Dictionary at 152.
[v] See Blanchard v. Kellum, D.D.S., 975 S.W.2d 522 (Tenn. 1998).
[vi] See Julie Zabensky v. Lawrence & Memorial Hospital et al., 1999 Conn. Super. LEXIS 2085.
[vii] Caron v. Adams, 33 Conn. App. 673, 688, 638 A.2d 1073 (1994).

EMTALA Update

Introduction

Each quarter TSG will bring you up to date on recent changes related to EMTALA. This will involve review of proposed and final changes to the EMTALA regulations, new "Question and Answer" sessions on the CMS website, letters posted to the regional administrators, and any other source of information we can find.

1. **Name and Website Change.** As you are probably aware, the Health Care Financing Administration (HCFA) has changed its name to the Centers for Medicare & Medicaid Services (CMS). CMS is moving its website to cms.hhs.gov.

2. **Proposed Change to EMTALA Regulations.** CMS has published a proposed change in EMTALA regulations in the May 9, 2002 Federal Register.

On May 9, 2002, the Centers for Medicare and Medicaid Services (CMS) proposed significant revisions to the regulations stemming from the Emergency Medical Treatment and Active Labor Act (EMTALA). The proposed revisions affect important EMTALA obligations, and include: 1) deletion of most of the existing requirements that would have applied EMTALA to provider-based departments, both on-campus and off-campus; 2) an effort to clarify EMTALA's requirements regarding hospital emergency on-call panels; 3) clarification of what it means to "come to the emergency department," including the introduction of a new term, the "dedicated emergency department"; 4) a new restriction on hospitals' ability to obtain prior authorization from payors during the medical screening examination and stabilization process; 5) clarification of EMTALA's applicability to inpatients and to persons presenting with non-emergent conditions; and 6) clarification of EMTALA's applicability to hospital-owned ambulances.

Overview

Although providers will welcome most of these revisions, the likely effect of some proposed changes seems less encouraging. On the positive side the new rule would repeal most of the recent rules extending EMTALA to hospital off-campus departments; if the off-campus department is one that does not routinely provide emergency services, the new rules would exempt the department from EMTALA's requirements. The rule would also clarify that EMTALA's obligations end when emergency patients are truly stabilized, and that EMTALA

does not apply to electively admitted patients, even if they develop an emergency medical condition after admission.

The less-positive changes include those relating to on-call coverage. Although the proposed rule seems well intentioned and seeks to clarify certain aspects of hospitals' EMTALA obligations, it may also create confusion about the duties of both hospitals and their medical staffs. Further, the rule seeks to integrate local EMS procedures into the obligations of hospital-owned ambulances with reduced risk of EMTALA violations. Ambiguity remains, however, regarding hospital obligations when ambulances contact the hospital by telephone or telemetry while en route to the hospital, but before the ambulance is on the hospital property.

Clarification of "Comes to the Emergency Department"

In perhaps one of the most significant proposed changes to the current EMTALA regulations, the proposed rule seeks to clarify exactly when a patient is deemed to have "come to the emergency department," thus triggering a hospital's EMTALA obligations. Explaining that questions arise when a patient does not present to the hospital's emergency department, but elsewhere on hospital property, the rule would create an EMTALA obligation in one of two ways: the individual can present at a hospital's "dedicated emergency department" and request examination or treatment for a medical condition; or the individual can present elsewhere on hospital property in an attempt to gain access to the hospital for emergency care (that is, at a location that is on hospital property but is not part of a dedicated emergency department), and request examination or treatment for what may be an emergency medical condition.

The proposed term "dedicated emergency department" is new to EMTALA, and would be defined as a specially equipped and staffed area of the hospital that is used "a significant portion of the time" for the initial evaluation and treatment of outpatients for emergency medical conditions, that uses the hospital's Medicare provider number, and is either located: (1) on the main hospital campus; or (2) off the main hospital campus and is treated as a department of the hospital. Such departments may include labor and delivery departments that provide emergency or labor and delivery services or psychiatric units, or other departments that are held out to the public as appropriate places to come for urgent medical services.

This new definition is helpful, but would create additional hospital EMTALA burdens. The concept of a "dedicated emergency department," as defined, clarifies the scope of hospital EMTALA obligations, and is very important to the proposed regulation's sweeping curtailment of EMTALA obligations previously imposed on off-campus and outpatient departments. It appears that most urgent care units would fall within the definition of a dedicated emergency department. Thus hospitals that thought EMTALA affected them very little because they had no emergency department may find themselves subject to the law because they do operate an urgent care service.

On-Call Requirements

The proposed rule would clarify that hospitals can maintain a certain amount of flexibility in determining its level of emergency department on-call coverage without fear of violating EMTALA, and that the hospital has the discretion to maintain coverage "in a manner to best meet the needs" of its patients. The proposed rule explicitly states that a hospital "must maintain an on-call list of physicians," but the preamble explains that EMTALA does not require a specific level of coverage in terms of how frequently available the specialists are to the emergency department. In fact, the rule also explicitly states that "physicians, including specialists and subspecialists, are not required to be on call at all times." The preamble explains that there is no predetermined ratio that CMS uses to identify how many days a hospital must provide on-call coverage.

The proposed rule regarding on-call coverage simply restates CMS's long-standing interpretation of EMTALA's requirements in that regard, and is fully consistent with CMS's prior pronouncements on the matter. Unfortunately, physicians may misinterpret the rule's statements to mean that on-call obligations are more optional than mandatory. That is not true. CMS has long taken the position that call panels must be a reasonable reflection of the hospital's medical staff. For example, if a hospital offers orthopedic services to the inpatient population, orthopedic services must also be available to emergency patients and are subject to EMTALA's stringent requirements.

What the proposed rule means is that the extent of coverage will vary from hospital to hospital, depending on circumstances. By way of example, CMS states in the preamble that it will consider all relevant factors, including the number of physicians on staff, other demands of the physicians, the frequency with which the hospital's patients typically require on-call services, and the provisions the hospital has made for situations in which a physician in the specialty is not available or the on-call physician is unable to respond. The proposed rule also states that a hospital must have policies and procedures for when a particular specialist is not available or unable to respond for reasons beyond his or her control.

Hospitals and their medical staffs will need to be vigilant regarding compliance education in this regard. The preamble's broad statements about a hospital's "flexibility" in making call arrangements, and the statement that physicians need not be on call at all times, may lead some physicians to believe that their hospital's obligation to arrange emergency department coverage is much less stringent than the law provides.

Individuals Presenting for Nonemergency Services

CMS acknowledged that there is confusion among hospitals about whether EMTALA's requirements apply to a situation in which an individual comes to a hospital's dedicated emergency department, but no request is made for emergency medical evaluation or treatment. An example of such situations includes scheduled appointments for radiology services. The proposed rule responds to this concern by stating explicitly that if an individual comes to a hospital's dedicated emergency department and a request is made on his or her behalf for examination or treatment for a medical condition, but the nature of the request makes it clear that the medical condition is not emergent, the hospital is required only to perform such screening as would be appropriate for any individual presenting in that manner, to determine that the individual does not have an emergency medical condition.

The preamble offers an example: A patient comes to the emergency department requesting routine suture removal at the time specified by the person who sutured her wound. After a "qualified medical person," as defined in the regulations, examines the wound and determines that the well-healing sutures do not constitute an emergency medical condition, the hospital has satisfied its EMTALA obligations and may refer the patient elsewhere for the routine services.

This change is helpful, but still requires hospital personnel to exercise judgment in individual cases. Revisions to compliance policies and related training materials will be necessary. Emergency department personnel would be wise to resolve doubts in favor of applying EMTALA's obligations.

Individuals Presenting at an Area Other Than the Dedicated Emergency Department

In press releases related to the proposed rule, CMS states its desire to introduce "common sense" into EMTALA enforcement. In that regard, the proposed rule seems to succeed in its efforts to answer the question of whether EMTALA applies to every individual who appears on a hospital's property for the purpose of receiving medical attention.

In the preamble to the proposed rule, CMS notes that a hospital would incur an EMTALA obligation to an individual presenting to an on-campus area of the hospital (other than the dedicated emergency department) and who requests examination or treatment for what may be an emergency medical condition, even if an emergency medical condition is ultimately found not to exist. This is universally understood and accepted among the provider community.

The proposed rule would clarify that a request for emergency treatment is considered to exist if the individual requests examination or treatment for what the individual believes to be an emergency medical condition. Where there is no actual request because, for example, the individual is unaccompanied and is physically incapable of making a request, the request from the individual would be considered to exist if a prudent layperson observer would believe, based upon the individual's appearance or behavior, that the individual needs emergency examination or treatment.

Under the proposed rule, a request for examination or treatment by an individual presenting for what may be an emergency medical condition at an on-campus area of the hospital other than the dedicated emergency department would not have to be expressed verbally in all cases. The preamble explains that this policy does not mean that the hospital must maintain emergency medical screening or treatment capabilities in every department or at each door of the hospital, nor anywhere else on hospital property other than the dedicated emergency department, as long as the hospital as a whole is able to screen and stabilize the patient. The preamble further notes that if hospital personnel arrange to have an individual with an obviously bleeding scalp laceration taken to the dedicated emergency department, and the staff arrives within minutes to transport the individual to the emergency department to complete the screening and treatment, the hospital has met its EMTALA obligations.

But the proposed rule also would clarify limits to EMTALA's scope. The law would not apply to an individual who comes to the hospital as an outpatient for nonemergency purposes, even if that individual experiences what may be an emergency medical condition while at the hospital (for example, a patient who begins experiencing chest pain while receiving outpatient physical therapy after knee surgery). Providers have long maintained that the law ought to be interpreted in this manner.

The preamble explains, however, that although such an outpatient would not be entitled to EMTALA's protections, he would still have all protections afforded to

patients under the Medicare hospital conditions of participation. Hospitals that fail to provide treatment to these patients could face termination of their Medicare provider agreements for a violation of the conditions of participation. The preamble further explains that, as patients of a health care provider, these individuals are accorded protections under State statutes or common law as well as under general rules of ethics governing the medical professions.

Prior Authorization

EMTALA provides that hospitals may not delay screening or stabilization services in order to inquire about an individual's method of payment or insurance status. In the past neither EMTALA nor the related regulations have addressed the question of seeking authorization from insurance companies or managed care plans prior to providing screening or stabilization. Delay seemed to be the key issue, and as long as screening and stabilization services were proceeding without delay, providers have assumed that contacting payors for authorization was not prohibited, as long as the hospital did not act on a denial of authorization. In November 1999, CMS and the Office of Inspector General (OIG) issued a "Special Advisory Bulletin" stating the government's recommendations on such matters. The CMS/OIG recommendation was that hospitals not seek payor authorization until after the hospital has provided the required medical screening examination and has initiated necessary stabilizing treatment. The proposed rule would make that recommendation a legal requirement.

This change would create a new compliance pitfall for hospitals. Now, most hospitals probably follow the CMS/OIG recommendation and do not seek payor authorization until stabilizing treatment is under way. Many hospitals, however, probably seek authorization as a matter of course, independent of the screening or stabilizing treatment a patient is receiving. This is not a recommended practice, but it is not prohibited. If the proposed regulation becomes final, hospitals engaging in such contacts will be in violation of EMTALA. Hospitals will need to revise compliance policies and training outlines accordingly.

Applicability to Hospital Inpatients

In yet another clarification that providers have long maintained should be the law, the preamble states that under the proposed rule, EMTALA generally does not apply to inpatients. The rule carefully clarifies, however, that inpatient status is not the key to EMTALA's applicability. The real question is whether the patient's emergency medical condition has been stabilized.

To meet EMTALA's stabilization requirements, a patient who is admitted to the hospital from the dedicated emergency department must be truly stabilized within the law's definition, and an admitted patient who goes in and out of apparent stability would not be considered stabilized under EMTALA.

Under the proposed rule, EMTALA's obligations end at stabilization. If the condition of an inpatient who is stabilized according to these criteria later deteriorates, either as a result of the admitting emergency condition or for a new condition, the hospital is not bound by EMTALA.

The proposed rule would also clarify that EMTALA does not extend to an admitted nonemergent inpatient if there is a deterioration of that patient's condition. In other words, patients who come to the hospital seeking elective diagnosis or treatment would not fall under EMTALA's protection.

This clarification is welcome news to providers and, if it becomes final, resolves a long-running debate among policy-makers and even among federal courts on the scope of EMTALA's applicability to inpatients.

Applicability to Provider-Based Entities: Off-Campus Departments

Attempting to clarify the scope of EMTALA's applicability to off-campus departments, the rule would narrow the applicability of EMTALA to only off-campus departments that would be considered "dedicated emergency departments" in their own right. Whether such an off-campus department would be considered a dedicated emergency department would turn, not on whether the department is identified to the public as an "emergency room" or "emergency department," but rather on whether a "prudent layperson" would perceive the department as an appropriate place to go for emergency treatment.

Consistent with this clarification that EMTALA does not apply to off-campus departments other than dedicated emergency departments, the proposed rule would delete entirely 42 CFR Section 489.24(i), because that section's primary purpose is to describe a hospital's EMTALA obligations with respect to non-emergency off-campus departments. This is a remarkable reversal by CMS of what was a broad-ranging and controversial expansion of EMTALA's obligations.

The proposed rule would, however, add language to clarify that if emergency services are provided at the hospital but not at one or more off-campus departments, the governing body of the hospital must ensure that the medical staff of the hospital has written policies and procedures in effect

with respect to those departments for evaluation and referral of emergencies. Hospitals already have a similar obligation under the Governing Body portion of the Medicare conditions of participation, and so this revision to that part of the conditions would only clarify that the governing body's obligation regarding the main hospital campus also extends to off-campus departments.

Applicability to Provider-Based Entities: On-Campus Departments and Entities

The proposed rule would attempt to clarify that EMTALA applies only to those on-campus departments that are provider-based, and not to on-campus provider-based entities because the latter are not under the certification and provider number of the main provider hospital. Provider-based entities include skilled nursing facilities, rural health facilities, physician offices, restaurants, shops, or other nonmedical facilities. EMTALA would not apply to such facilities, even if they are located on the hospital's main campus, as defined in 42 CFR Section413.65(b).

Applicability to Ambulances

A hospital's EMTALA obligation is currently triggered when a patient is in an ambulance that is owned and operated by the hospital, even if the ambulance is not on hospital property. The proposed rule clarifies that, if a hospital-owned ambulance participates in community-wide EMS protocols that require the ambulance to transport patients to the nearest hospital, EMTALA would not apply. In that case, a patient would be deemed to have come to the emergency department of the hospital to which he or she is transported at the time he or she is brought onto that hospital's property.

Although helpful, this revision does not address the confusion created by language in the existing regulation. Currently, the EMTALA rules seem to provide that once an ambulance contacts a hospital by radio and informs the hospital that the ambulance is en route with a patient, the hospital may not refuse the patient unless it is on diversionary status. CMS has long stated that it does not so interpret the existing rule. At least one federal appellate court disagrees, however. In Arrington v. Wong, the United States Court of Appeals for the Ninth Circuit held that a hospital is in fact obligated under EMTALA as soon as an ambulance contacts the hospital, unless the hospital is on diversion. This problem could be resolved if CMS simply deleted the language in the regulations referring to diversion, which CMS apparently interprets differently than the Ninth Circuit does.

Conclusion

The proposed EMTALA revisions should be welcome to most providers. For the most part, the new rule would clarify and improve EMTALA's requirements, and would simplify compliance. Some important ambiguities and burdensome provisions remain, however. The comment period on the proposed new rule will provide an opportunity for providers to make known their views on those issues. CMS is asking for public comment on all the proposed changes, and the comment period ends on July 8, 2002. The publication date of the final rule is scheduled for August 1, 2002.

3. **EMTALA Public Education.** CMS has increased its efforts at public education regarding EMTALA and supporting regulations. TSG strongly recommends reviewing the "Question and Answer" offerings by CMS. CME specifically addresses multiple topics including:

- The definition of Campus.
- The 250-yard rule.
- Options for transporting patients from the off-campus outpatient department back to the hospital emergency department.
- Appointments vs. walk-ins at the off-campus outpatient departments.
- Screening requirements on the off-campus outpatient departments.
- The nature of the screening exam in the off-campus outpatient departments.
- Staffing in off-campus departments under EMTALA.
- The requirement to designate a qualified medical provider in outpatient departments.
- Critical communications issues between the off-campus department and the emergency department.
- Is 911 sufficient?
- Transfer agreement requirement with the closest emergency department.
- Signage requirements in the off-campus departments.

TSG strongly recommends reading this Q & A at the following website: www.hcfa.gov/medlearn/emqsas.htm. You cannot be current with EMTALA without it.

4. **EMTALA and Advanced Beneficiary Notices.** Hospitals and emergency physicians have expressed concern over the requirement to get Medicare patients to sign Advanced Beneficiary Notices (ABN). In order to bill a patient for a service when a physician is uncertain whether Medicare covers the service, the physician must request that the beneficiary sign an ABN stating that he or

she understands that the service may not be covered by Medicare and that the beneficiary will pay for the service if Medicare does not cover it. In contrast, EMTALA requires that patients be screened and stabilized before they can be asked about insurance coverage. Because EMTALA prohibits a physician from discussing Medicare's coverage of services and whether the patient is willing to pay for services that are not covered, emergency department physicians are not having beneficiaries complete ABN forms before a test or service is ordered or provided. As a result, these physicians are unable to bill patients for a service if the service is provided and subsequently not paid for by the Medicare program.

CMS points out that ABNs may still be completed, but it must occur in compliance with EMTALA requirements.

For more information on ABNs, refer to the Q & A on the CMS website at:
http://www.hcfa.gov/medlearn/fagemtala.htm

5. **Q & A on Bioterrorism.** CMS has specifically addressed the hospital's responsibilities under EMTALA in the event that patients present to the emergency department following an act of bioterrorism. Essentially, CMS indicates that the hospital may follow community plans regarding referral of such patients. Thus, if a patient presented to the hospital with a potential anthrax exposure, but a regional EMS plan had designated another hospital as a receiving facility for such an incident, the hospital may send the patient without fear of violating EMTALA.

Find this information at:
http://www.hcfa.gov/medicaid/ltcsp/110801.htm

6. **CMS Letter on False Labor and Physician Certification.** On January 16, 2002, the CMS Survey Director, Mr. Steven Pelovitz, published a memo to Associate CME Regional Administrators regarding the management of pregnant women and the diagnosis of "true labor" and "false labor." In the letter, Mr. Pelovitz indicates that under the EMTALA regulations (section 489.24 (a)), any Qualified Medical Provider (QMP) may determine that a woman is in "true labor" which is an emergency medical condition. However, under section 489.24, a physician must make a determination that a pregnant woman is in "false labor" and does not have an emergency medical condition. The following is an excerpt from that letter:

The regulation at § 489.24 (b) specifies, however, that "a woman experiencing contractions is in 'true labor' unless a physician certificates that…the woman is in false labor." Therefore, when a QMP diagnoses a woman to be in "false labor," a physician is required to certify that diagnosis before the patient can be discharged.

Discussion

Why the letter? There has always been consternation over the definitions of "true labor" and "false labor." There has also been confusion, related to EMTALA, regarding the screening examination of third trimester pregnant women presenting to hospitals. In many cases women are sent directly to the labor and delivery suite and are not seen by an emergency physician. Experience suggests that it has been acceptable practice for hospitals to designate labor and delivery nurses as "qualified medical providers" for evaluation of this patient group. Many hospitals utilize OB/GYN nurses in this fashion, with an OB/GYN physician available for telephone consultation

Remember the QMP is that person or persons identified by the hospital as designated to provide medical screening examinations under EMTALA. Also, be aware that CMS requires that the hospital governing body participate in this designation process.

According to this letter, a QMP labor and delivery nurse can make a determination that a patient is in labor. However, a physician is required to "certify" that a woman is in "false labor" and can be discharged home.

Taber's Medical Dictionary defines "false labor" as uterine contractions occurring before the onset of actual labor. In Tintinalli, false labor is defined as uterine contractions that do not lead to cervical changes. Tabor's does not define "true labor." Tintinalli describes true labor as characterized by painful, regular contractions of steadily increasing intensity and duration leading to progressive cervical dilatation. In general, a woman is considered to be in labor or "active labor" if there are regular uterine contractions with increasing dilatation of the cervix and descent of the presenting part.

For purposes of this EMTALA discussion and for evaluation of this patient group, assume that if there are regular uterine contractions with increasing dilatation of the cervix, a woman is in "true labor;" otherwise the patient is in "false labor" or is not in labor. This assumes no complications of the pregnancy.

Mr. Pelovitz's letter is focused on the need for physician certification when a qualified medical person determines that the patient is in false labor or is not in labor. What is the certification requirement? Certification is a written assurance that some act has occurred or a legal formality has been complied with (Black's Law Dictionary 6th edition). Therefore, it seems the QMP, in this case the labor and delivery nurse, can continue to make the clinical

judgment, but there should be a written assurance by a physician: a certification that the evaluation has occurred and that the screening examination required by EMTALA has been complied with. Based upon this letter, the regional administrators may be looking for this written certification when evaluating your hospitals for EMTALA compliance. For the full text of the letter go to: http://www.hcfa.gov/medicaid/ltcsp/011602.htm

7. **OIG Strengthens EMTALA Civil Monetary Penalty Provisions.** In the March 18th Federal Register, the Office of the Inspector General (OIG) published final rules that broaden the scope of inquiry for evaluation of civil monetary penalties. Prior to this regulatory change, the OIG and Administrative Law Judges (ALG) could consider only the results of prior formal hearing processes in determining the penalty. This change would allow the OIG to consider other "instances" of conduct not necessarily related to formal legal or regulatory proceedings.

From the March 18th Federal Register:

K. Calculation of Penalty Amount for Patient Dumping Violations

Proposed change: The existing language in Sec. 1003.106(a)(4) allows the OIG to take into account a "prior history of offenses" with respect to patient dumping in determining the amount of CMP imposed for a patient dumping violation. We proposed an amendment [[Page 11931]] to Sec. 1003.106(a)(4)(iii) that would allow the OIG and the administrative law judge (ALJ) to consider other "instances"- and not just "offenses" - regardless of when they occurred, that is, not just "prior to" the matter conduct upon which the CMP action is based.

Comment: Commenters expressed the view that CMP amounts in patient dumping cases should be based only on judgments and other actions, which have been adjudicated, such as convictions or administrative sanctions. The commenters believed that allowing the OIG the authority to "bypass" courts and the administrative appeals process would penalize physicians for alleged behavior that has not been ruled upon by a court or an ALJ. One commenter stated that in determining CMP amounts under this provision, the OIG should only be allowed to cite subsequent offenses to the same extent that the OIG now considers prior offenses. Without such limitation, the commenter believed that physicians' due process rights would be violated since they would not be able to contest the underlying alleged behavior.

Response: In assessing the appropriate CMP amount in a dumping case, we continue to believe that it is appropriate to include matters, which occurred after the events that resulted in the OIG's issuance of a letter to a provider proposing a CMP. Specifically, with respect to the provider's "prior history," we have found instances, which may occur several years later between the time of the initial event and the initiation of litigation, where a provider has committed other acts similar in nature to the violation that is the basis for the proposed CMP. The OIG believes that those other similar acts should be considered so that an appropriate CMP can be determined and assessed.

By considering not just "prior history" as a factor, an appropriate penalty may be higher, for example, for a party with multiple instances of problematic conduct, as compared to a party who has only one such instance.

With respect to amending the current reference of "offenses" to "instances," we believe that the current term restricts consideration of incidents that are relevant to the provider's culpability but have not resulted in convictions, or judicial or administrative decisions. Because these prior similar incidents generally become known during the administrative appeals process, we believe that the term "offenses" is too limiting, and that the revision in the regulations will allow the OIG and the ALJs a broader range of conduct and options to consider in their determinations. The primary concerns expressed by the commenter do not apply because the ALJ will be able to fully evaluate all evidence in the record in deciding the amount of a CMP and give appropriate weight to such evidence. When the OIG is able to consider subsequent instances of conduct by the provider, the ALJ, Departmental Appeals Board and the courts will still remain free to accept or reject this additional information and evidence in determining an appropriate CMP amount.

Final rule revision: We are amending Sec. 1003.106 by adding a new paragraph (a)(4)(iii) to include as a factor in determining the amount of penalty for patient dumping violations any other instances where the respondent failed to provide appropriate **emergency** medical screening, stabilization and treatment of individuals coming to a hospital's **emergency** department, or to effect an appropriate transfer.

Disclaimer

Explanation of the various EMTALA issues may involve some degree of interpretation by TSG. TSG strongly encourages readers to seek legal counsel in evaluating the meaning and impact of rules, regulations, letters, and various statements and proclamations related to EMTALA. TSG does not claim to be authoritative or correct in its analysis of new information related to EMTALA. TSG does not claim to establish standards or guidelines related to EMTALA. ♦

EMTALA Case Review

Phillips v. Hillcrest Medical Center

UNITED STATES COURT OF APPEALS TENTH CIRCUIT

CRYSTAL STAR PHILLIPS, individually and as next of kin to Martin Shane Phillips, by and through her mother, legal guardian and next friend, MINNIE CHRISTINA DACZEWITZ; THE ESTATE OF MARTIN SHANE PHILLIPS; FRED MARTIN PHILLIPS, JR., parent of Martin Shane Phillips,

Plaintiffs - Appellants, v. HILLCREST MEDICAL CENTER, an Oklahoma corporation doing business in the State of Oklahoma,

Defendant - Appellee, and CAROLYN COBB, a physician; EMERGENCY PHYSICIANS, INC., an Oklahoma corporation doing business in the State of Oklahoma,

No. 00-5013

The United States Supreme Court recently denied review of the Case of Crystal Star Philips v. Hillcrest Medical Center. The Supreme Court cite contains very little information except the fact that they refused to review the case. The case itself comes out of the 10th circuit, and contains some very interesting reading relating to critical EMTALA concepts. The case focuses on the fact that screening examinations must be the same for similarly situated patients, and must follow department policies on screening. The case also explores EMTALA vs. negligence standards. We have highlighted in yellow some of the more important passages in the case. The TSG Discussion follows the case.

Appellants filed this action alleging federal and supplemental Oklahoma state law claims. See 28 U.S.C. §§ 1331, 1367(a). Prior to submitting the case to the jury, the district court granted appellee's Rule 50 motion as to the federal claim. The jury returned a verdict in appellee's favor with respect to the supplemental state law claim. The appeal of the district court's final judgment is now properly before this court. See 28 U.S.C. § 1291. We affirm.

I. Introduction

A. Facts

On Wednesday, September 23,1998, Martin Shane Phillips, accompanied by his friend and co-worker Mike Lulka, walked into the emergency room of Hillcrest Medical Center (HMC). Phillips complained of severe chest pain and pneumonia-like symptoms. Prior to examining Phillips, HMC staff took background information from Phillips, including whether he was covered under any health insurance plan. Phillips claimed he was covered but could not locate his insurance card. Lulka, who was covered under the same plan from their mutual employer, offered his card to provide HMC administrative staff with the generic information that was equally applicable to the co-workers. HMC staff allegedly indicated on his file that Phillips was not insured.

After initial processing, Phillips was "triaged" by Lugenia Cue, a registered nurse, and then examined by Dr. Carolyn Cobb in the minor care side of the emergency room. After the examination, Phillips was given two prescriptions, discharged from the emergency room, and referred to an Oklahoma medical clinic for follow-up treatment. Though his symptoms failed to subside, Phillips was seen at work on the two days (Thursday and Friday) following his discharge from HMC. Based upon all accounts, his condition was rapidly deteriorating through Saturday and Sunday.

Late Sunday night or early Monday morning, Fred Phillips, decedent's father, decided to take Phillips to the emergency room at Tulsa Regional Medical Center (TRMC). They arrived at TRMC, claiming Phillips had been suffering from nausea and vomiting for four to five days. Phillips again gave demographic information and denied, as he had on September 23, the use of illegal drugs. Phillips was initially examined by an emergency room doctor, Dr. Phillip Murta. Dr. Murta believed Phillips was suffering from pneumonia. Dr. Stan Stacy later relieved Dr. Murta and became concerned plaintiff's condition was the result of something more serious than pneumonia. After performing additional tests, Dr. Stacy confirmed Phillips was suffering from bacterial endocarditis. Phillips' condition worsened and he was pronounced dead on September 28, 1998. All parties agree the cause of death was acute bacterial endocarditis.

B. Procedural History

Plaintiffs sued Hillcrest Medical Center, Dr. Carolyn Cobb, and Emergency Physicians, Incorporated (later amended to Tulsa Emergency Physicians, Incorporated (TEP)). The suit related only to the evaluation, diagnosis, and treatment provided Phillips on September 23, 1998. Plaintiffs alleged

defendants violated the Emergency Medical Treatment and Active Labor Act (EMTALA) and also brought a claim for wrongful death under Oklahoma medical malpractice law for failing to properly treat Phillips.

Prior to trial, the district court dismissed the EMTALA claim against Dr. Cobb and TEP. The remaining claims were presented to a jury. At the close of evidence, the district court sustained HMC's Rule 50 motion, holding no EMTALA claim existed as a matter of law, and sustained appellants' Rule 50 motion that Dr. Cobb was the agent of HMC. The district court submitted the issue of medical malpractice/wrongful death to the jury and a verdict in favor of HMC was returned. Plaintiffs filed this appeal.

C. Summary of Issues on Appeal

On appeal, appellants raise four issues. Appellants allege the district court erred in (1) granting HMC's Rule 50 motion as to the EMTALA claim, (2) admitting allegations of Phillips' drug use, (3) excluding plaintiffs' expert testimony regarding the cause of bacterial endocarditis, and (4) refusing to allow cross-examination of HMC's nurse regarding Exhibit 25 and Exhibit 26.

II. Analysis

A. EMTALA

Appellants argued at trial that HMC treated Phillips differently than similarly situated patients because he was alleged to be uninsured and that HMC's established procedures were not followed. The district court ruled no evidence of differential treatment was presented and, at most, the complained of conduct amounted to negligence. See Vol. II, pp. 844-45. At the invitation of the district court, appellants are now pressing similar argument before this court.

1. Standard of Review

This court reviews the grant of judgment as a matter of law de novo, sitting in the same position as the trial court. See Tyler v. Re/Max Mountain States, Inc., 232 F.3d 808, 812 (10th Cir. 2000). Pursuant to Rule 50 of the Federal Rules of Civil Procedure, a trial judge may grant a motion for judgment as a matter of law if, after a party has been fully heard on an issue, there is no legally sufficient evidentiary basis for a reasonable jury to find for the party on that issue. See Tyler, 232 F.3d at 812; Finley v. United States, 82 F.3d 966, 968 (10th Cir. 1996). This court has read FRCP 50(a) to mean judgments as a matter of law may be granted "only if the evidence points but one way and is susceptible to no reasonable inferences which may support the opposing party's position." Finley, 82 F.3d at 968; see also Tyler, 232 F.3d at 812 (relying upon Reeves v. Sanderson Plumbing Prods., Inc., 530 U.S. 133 (2000)) . As such, the facts and all reasonable inferences from them are viewed in the light most favorable to the appellant. See Finley, 82 F.3d at 968.

2. Legal Framework

Congress enacted EMTALA in 1986 to address the problem of "dumping" patients in need of medical care but without health insurance. See Abercrombie v. Osteopathic Hosp. Founders Ass'n, 950 F.2d 676, 680 (10th Cir. 1991); Stevison v. Enid Health Sys's, 920 F.2d 710, 713 (10th Cir. 1990). Though originally intended to cure the evil of dumping patients who could not pay for services, the rights guaranteed under EMTALA apply equally to all individuals whether or not they are insured. See Collins v. DePaul Hosp., 963 F.2d 303, 308 (10th Cir. 1992) (stating EMTALA also applies to those who are covered by health insurance); see also Summers v. Baptist Med. Ctr. Arkadelphia, 91 F.3d 1132, 1137 (8th Cir. 1996) (en banc) (stating the statute literally applies to "any individual" so a lack of indigency or uninsured status does not defeat an EMTALA claim). Thus, whether Phillips was or was not actually covered by his employer's insurance plan is of no consequence to the resolution of this issue on appeal.

Under EMTALA, a participating hospital has two primary obligations. See Ingram v. Muskogee Reg'l Med. Ctr., 235 F.3d 550, 551 (10th Cir. 2000). First, the hospital must conduct an initial medical examination to determine whether the patient is suffering from an emergency medical condition. See Abercrombie, 950 F.2d at 680. The second obligation requires the hospital, if an emergency medical condition exists, to stabilize the patient before transporting him or her elsewhere. See Urban v. King, 43 F.3d 523, 525 (10th Cir. 1994). To ensure compliance with these obligations, Congress created a private cause of action. See 42 U.S.C. § 1395dd(d); Repp v. Anadarko Mun. Hosp., 43 F.3d 519, 521-22 (10th Cir. 1994). Appellants' only claim under EMTALA is for an alleged failure to provide an appropriate screening as required by section 1395dd(a).

Pursuant to section 1395dd(a), HMC was required to conduct an "appropriate medical screening examination . . . to determine whether or not an emergency medical condition . . . exists." 42 U.S.C. § 1395dd(a). This court has stated that whether a given hospital has performed an "appropriate medical screening examination," as defined by EMTALA, varies with the unique capabilities of the specific hospital. See Repp, 43 F.3d at 522. Further, we give appropriate deference to the existing screening procedures utilized by the hospital, because it, not a reviewing court, is in a superior position to determine its own capabilities and limitations. See id. at 522 & n.4 ("A

court should ask only whether the hospital adhered to its own procedures, not whether the procedures were adequate if followed."). Based upon those pre-existing procedures, adopted and employed by a hospital, the Repp court held EMTALA's screening requirement is violated "when it does not follow its own standard procedures." See id. at 522.

The underlying principle behind section 1395dd(a) is to ensure all patients, regardless of their perceived ability or inability to pay for medical care, are given consistent attention. EMTALA's requirement of an "appropriate screening examination" undeniably requires HMC to "apply uniform screening procedures to all individuals coming to the emergency room." Vickers v. Nash Gen. Hosp. Inc., 78 F.3d 139, 143 (4th Cir. 1996) (stating uniform treatment for all patients, regardless of ability to pay, is considered "the linchpin of an EMTALA claim"). While this court has never expressly described the obligation under EMTALA in terms of uniform or disparate treatment, several of our sister circuits, as well as numerous district courts within this circuit, have. See id.; Marshall v. East Carroll Parish Hosp. Serv. Dist., 134 F.3d 319, 323 (5th Cir. 1998); Summers, 91 F.3d at 1138; Holcomb v. Monahan, 30 F.3d 116, 117 (11th Cir. 1994); Scott v. Hutchinson Hosp., 959 F. Supp. 1351, 1357 (D. Kan. 1997) ("A hospital satisfies the requirements of § 1395dd(a) if its standard screening procedure is applied uniformly to all patients in similar medical circumstances."); Tank v. Chronister, 941 F. Supp. 969, 972 (D. Kan. 1996) (quoting Vickers, 78 F.3d at 144) ("EMTALA is implicated only when individuals who are perceived to have the same medical condition receive disparate treatment . . . ."). To the extent it was unclear before, this court holds, as it implicitly did in Repp, a hospital's obligation under EMTALA is measured by whether it treats every patient perceived to have the same medical condition in the same manner. "Disparate treatment" is simply another term for describing or measuring a hospital's duty to abide by its established procedures. Unless each patient, regardless of perceived ability or inability to pay, is treated in a uniform manner in accordance with the existing procedures, EMTALA liability attaches. See Repp, 43 F.3d at 522.

3. Appellants' Claims

Appellants argued to the district court, as they have here, that evidence of a bias towards those who are uninsured is sufficient to state an EMTALA claim. They point to the testimony of Mike Lulka regarding the initial intake procedures HMC undertook and attempt to extrapolate an intolerance towards those perceived to be uninsured.[8] They also look for support in Christina Daczewitz's testimony that she saw, some time after Phillips' death, a notation of "no insurance" on Phillips' medical records at HMC. Appellants' repeated attempts to introduce evidence regarding HMC's motives are irrelevant to whether Phillips was treated in a manner consistent with HMC's existing procedures. This circuit, like many others, does not require any particular motive for EMTALA liability to attach. See Repp, 43 F.3d at 522 n.5 (stating EMTALA imposes strict liability). EMTALA looks only at the participating hospital's actions, not motives. See Stevison, 920 F.2d at 713 ("We construe [section 1395dd(a)] as imposing a strict liability standard subject to those defenses available in the act."); see also Roberts v. Galen of Virginia, 525 U.S. 249, 252 (1999) (stating the Sixth Circuit's requirement of an improper motive is in conflict with several circuits, including the First, Fourth, Eighth, and D.C. Circuit). While testimony regarding a hospital's knowledge of a patient's lack of insurance coverage may be relevant to explain a failure to abide by established procedures, it alone does not establish a violation of EMTALA's requirement of uniform treatment.

Moving to the crux of their EMTALA claim, appellants attempted to identify certain HMC policies they claim were not followed. During the Rule 50 colloquy, the district court asked appellants to point to the evidence adduced in support of the EMTALA claim. See Vol. II, p. 827. As they have before this court, appellants pointed to Exhibit 47 (Vol. IV) and an unidentified discharge policy, claiming various aspects of these policies were not followed. The district court repeatedly implored appellants' counsel to describe the evidence showing that HMC failed to screen and evaluate Phillips' condition. In the interest of brevity, it is sufficient to say appellants' counsel reluctantly conceded HMC, either through Nurse Cue and/or Dr. Cobb, did in fact make a determination as to Phillips' condition with respect to each and every allegation of failure to abide by existing policy requirements. See Vol. II, p 829, ln. 19-20; Id. at p. 830, ln. 11 - p. 831, ln. 4; Id. at p. 831, ln. 5 - p. 832, ln. 4; Id. at p. 843, ln. 11 - p. 844, ln. 12. Based upon these admissions and in reliance upon Repp and Tank v. Chronister, 941 F. Supp. 969 (D. Kan. 1996), the district court stated that so long as HMC performed a medical screening examination, consistent with its policies and in an effort to discern whether Phillips was suffering from an emergency medical condition, EMTALA was satisfied.

Appellants' argument brings into focus the uneasy intersection between EMTALA and state law medical negligence claims. They argue HMC staff failed to appropriately identify and/or appreciate the gravity of Phillips' condition. In other words, while they concede HMC technically complied with their pre-existing standards, the practical effect was an inadequate examination. EMTALA was not, however, designed for

such a claim. Though it created a new cause of action, we have consistently recognized EMTALA's provisions have only a limited reach and purpose. See Ingram, 235 F.3d at 552 (citing several cases for the proposition that EMTALA's limited purpose was to eliminate "patient-dumping").

EMTALA does not set a federal standard of care or replace pre-existing state medical negligence laws. See, e.g., Repp v. Anadarko Mun. Hosp., 43 F.3d 519, 522 (10th Cir. 1994); Power v. Arlington Hosp. Ass'n, 42 F.3d 851, 856 (4th Cir. 1994) ("EMTALA is not a substitute for state law malpractice actions, and was not intended to guarantee proper diagnosis or to provide a federal remedy for misdiagnosis or medical negligence."). While providing a guaranty for an "appropriate medical screening," EMTALA, unlike traditional state negligence or malpractice law, does not provide a remedy for an inadequate or inaccurate diagnosis. See Vickers, 78 F.3d at 142. For example, in Collins v. DePaul Hospital, we stated the purpose of section 1395dd(a)'s screening examination "is to determine whether an 'emergency medical condition exists.' Nothing more, nothing less." Collins, 963 F.2d 303, 306-07 (10th Cir. 1992) (footnote omitted). Thus, while appellants were allowed to go to the jury with their medical malpractice claim for the alleged conduct of HMC's staff,[9] the district court was, as a matter of law, correct in stating no evidence of an EMTALA claim was presented.

Additional elements of the case have been deleted as not relevant to the EMTALA issues. For a full review go to the web site: http://www.kscourts.org/ca10/cases/2001/03/00-5013.htm

III. Conclusion

After a thorough review and analysis of all issues fairly presented, we AFFIRM.

TSG Discussion

The federal courts typically follow a strict interpretation of the EMTALA statute and regulations. They follow the "plain language of the law and regulations," and precedent.

With regard to the standard for screening examinations, two standards are most often proposed. The first is the hospital must follow established policy and protocol for screening examinations. That is the standard that was used in this case. Since the plaintiff could not identify a policy or procedure that was not followed, the case failed at the trial court level, and the appellate court could not find fault with that decision.

The second standard often utilized is that the screening examination must be adequate to reasonably determine whether an emergency medical condition does or does not exist. Thus, in a patient with a severe headache, the screening examination may reasonably consist of a history and physical exam, followed by imaging studies and perhaps a lumbar puncture. All may be necessary in order to determine if the patient is suffering from an emergency medical condition. In this case obviously, ruling out a subarachnoid hemorrhage.

In considering the medical screening examination at your facility, consider both standards. Carefully review policy and procedures, if they exist, because that will be the standard you will be held to in an EMTALA evaluation by the courts. In addition, consider educating your physician and nursing staff about the second standard. Doing what is reasonably necessary to determine if the patient has an emergency medical condition. ♦

Landmark Case Review

TSG will present landmark cases in this section of the newsletter. In general, a landmark case is one that significantly changes existing law. We will expand that definition to include a wider range of cases that have, or could have had, a significant impact on the practice of emergency medicine.

Coleman v. Deno

Appellate Citation

*787 So. 2d 446, *; 2001 La. App. LEXIS 1203, **

LOUIS COLEMAN, INDIVIDUALLY AND AS FATHER OF LOUIS FRANK COLEMAN VERSUS DR. RICHARD DENO, DR. IVAN SHERMAN AND JOELLEN SMITH HOSPITAL

No. 99-CA-2998

COURT OF APPEAL OF LOUISIANA, FOURTH CIRCUIT

99-2998 (La.App. 4 Cir, 04/25/01); 787 So. 2d 446; 2001 La. App. LEXIS 1203

April 25, 2001, Decided

Louisiana Supreme Court Citation

*2002 La. LEXIS 142, **

LOUIS COLEMAN, INDIVIDUALLY AND AS FATHER OF LOUIS FRANK COLEMAN Versus DR. RICHARD DENO, DR. IVAN SHERMAN AND JOELLEN SMITH HOSPITAL

No. 01-C-1517 c/w 01-C-1519 c/w 01-C-1521

SUPREME COURT OF LOUISIANA

01-1517 (La. 01/25/02); 2002 La. LEXIS 142

January 25, 2002, Decided

Introduction

Although the emergency department visits at issue occurred in 1988, the legal decisions are recent, and are of great importance to emergency practitioners. In this case, the Louisiana appellate courts transformed the private cause of action under EMTALA, which can only be brought against a hospital, into an intentional tort, which was brought against the emergency physician. This result caused many emergency physicians in Louisiana to give serious consideration to packing their bags and practicing in another state. Fortunately the Supreme Court understood the law and overturned the Appellate Court decision.

Fact Summary

June 7, 1988: Mr. Coleman appeared at the emergency department of JoEllen Smith Hospital, (JESH), complaining of pulling something in his chest and all movements hurt, including deep breathing. On that occasion, Mr. Coleman never complained of any problems with his arm. Rather, Mr. Coleman told the triage nurse that he had pulled something in his chest while lifting and that all movement hurts including deep breathing. With the exception of an elevated temperature (100.3 degrees F), his vital signs were normal. Dr. Ivan Sherman, the emergency room physician who examined Mr. Coleman, found his chest was clear, but his chest wall was tender. Dr. Sherman ordered an EKG and a chest x-ray. Based on the negative results of those tests and the physical examination, Dr. Sherman diagnosed chest pain and costochondritis. Mr. Coleman was discharged from the emergency department (ED).

June 8, 1988: Mr. Coleman returned to the JESH emergency department complaining that his left arm had begun to swell and ache that morning. Dr. Deno diagnosed Mr. Coleman with left arm cellulites and determined that Mr. Coleman needed intravenous antibiotic therapy. Dr. Deno decided that Mr. Coleman should be transferred to Charity Hospital of New Orleans, (Charity). Dr. Deno called the resident in charge of the ED at Charity and arranged for immediate admission. Dr. Deno determined that Mr. Coleman was capable of transporting himself. Mr. Coleman was discharged at 10:00 pm.

June 9, 1988: Mr. Coleman arrived at Charity at 12:21 a.m. He complained of left arm edema for one day. Mr.

Coleman was diagnosed with cellulitis, probable intravenous drug use, and the physician noted likely staph or strep infection, ruling out sepsis. Mr. Coleman was admitted.

June 11, 1988: Hospital notes report that the cellulitis with staph was responding to treatment with Nafcillin. Dr. Redmond found that Mr. Coleman had crepitus, indicating gas in the tissues of his left arm. Surgical consult occurred that day. Dr. Redmond found that the skin, fat, and bulk of the muscles in Mr. Coleman's left arm were dead as Mr. Coleman had developed a compartment syndrome within the past few hours. After consulting with an orthopedic Dr. Redmond performed an open left shoulder disarticulation and amputated Mr. Coleman's left arm at the shoulder.

June 28, 1988: Mr. Coleman was discharged.

July 27, 1990: Mr. Coleman filed a petition in civil court against Dr. Sherman, Dr. Deno, and JESH because they failed to properly treat and diagnose Mr. Coleman's left arm abrasion.

March 21, 1991: Mr. Coleman filed a supplement petition claiming that the defendant's violated COBRA's (now known as EMTALA) anti-dumping provision (Specifically claiming that Dr. Deno's act of transferring Mr. Coleman to Charity was negligent. Mr. Coleman claimed that Dr. Deno failed to treat Mr. Coleman at JESH because of his lack of insurance.)

Court of Appeals Issue: The appellate court noted that the issue before it was whether the Plaintiff stated a timely cause of action in his pleadings under LA general tort law for patient dumping?

Court of Appeals EMTALA Ruling: The appellate court's decision actually went outside the scope of the question before it. First the court noted that the patient dumping claims did not fall within the scope of Louisiana's Medical Malpractice Act. Further, the court noted that Mr. Coleman's amended petition correctly stated an intentional tort cause of action for improper transfer against Dr. Deno. This was an extraordinary ruling since this was not the question before the court. The court actually created a new precedent, using EMTALA to create a new intentional tort in the state of Louisiana.

Supreme Court Issue: Did the Court of Appeal err in recognizing an intentional tort cause of action against an emergency physician for improper transfer of a patient under general tort law?

Supreme Court EMTALA ruling: The court reversed the conclusion of the appellate court that Dr. Deno was additionally at fault under the general tort law for the *intentional* tort of "patient dumping".

Case Discussion

Important points:

1) The trial court granted Dr. Deno's motion to exclude any reference to EMTALA and Mr. Coleman's lack of insurance from the trial itself.
2) The court of appeals correctly concluded that the Louisiana Medical Malpractice Act only encompasses *unintentional* acts of negligence and contractual issues.
3) The court of appeals concluded that Mr. Coleman had no cause of action under EMTALA, the only anti-patient dumping provision that was referenced in Mr. Coleman's petition because that provision applies only to hospitals not to physicians.
4) The court of appeals crafted an *intentional* tort that was not plead, not prayed for in relief, not argued, not tried, and not submitted to the jury.
5) The first mention by Mr. Coleman of an intentional tort was in the Louisiana Supreme Court where, in an attempt to support the appellate court's creation of this new tort, he contends that Dr. Deno made a "deliberate decision" to transfer based on non-medical reasons.

What is a Tort?

A tort means any breach of duty or any negligent act or omission proximately causing injury or damage to another. A tort is not a criminal offense. It is a civil lawsuit between 2 people.

What is an Intentional Tort?

An intentional tort is defined by Black's Law Dictionary as "a tort in which the actor is expressly or impliedly judged to have possessed intent or purpose to injure." Common intentional torts are assault, battery, false imprisonment, and defamation.

Applying these concepts to Dr.Deno's situation means that the court of appeals felt that Dr. Deno intended to cause injury by not continuing to treat Mr. Coleman at JESH. The Court of Appeals thought that Dr. Deno's motion for transferring Mr. Coleman was solely because he did not have insurance to pay for his treatment at JESH. The court realized that this action was unrelated to medical treatment, thus not an issue found under the Louisiana medical malpractice act. It was also not an issue under EMTALA because only hospitals are liable under EMTALA. The Louisiana court of appeals reasoned that

there was no statute stopping them from finding, that under Louisiana tort law when a physician engages in the exact misconduct targeted by anti-dumping statutes (EMTALA) that the physician is guilty of an intentional tort.

The Louisiana Supreme Court reviewed this case on appeal from the physicians and hospital involved. The LA Supreme court determined that the court of appeals made a legal error in characterizing a claim for patient "dumping" as always giving rise to an intentional tort and in reasoning that a there is a clear difference from medical malpractice claims and patient "dumping" claims.

Conclusion

The Louisiana Supreme Court saved the day. Emergency physicians in Louisiana were extremely concerned about continuing practice in a state where an EMTALA violation was determined to be an intentional tort. After the appellate court decision, some physicians were considering leaving the state to practice in a less hostile environment. Cooler heads prevailed on the Supreme Court, and this end run around the law has been stymied. It is fortunate that we can discuss this case in the past tense! ♦

TSG Quarterly Report

At the crossroads of law and medicine

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The Emergency Medicine Risk Initiative

Patient Safety and Risk Reduction must be a major focus for all health care organizations and emergency practitioners. We must remove **identifiable** risk from the practice of emergency medicine.

TSG created the **Emergency Medicine Risk Initiative** (EMRI) following a decade of research into the causes of medical errors and litigation in emergency medicine. EMRI is a web-based program of education and ongoing evaluation addressing emergency department systems issues and individual practitioners care. EMRI is built on a foundation of:

- Yearly Risk Management Education
- Clear and concise risk and quality guidelines
- Continuous risk audits

The Educational Offerings are all web-based and include a High-Risk Acute Care Core Curriculum; Risk Self-Assessments in Emergency Care and EMTALA; EMTALA Courses for physicians, nurses and hospital administrators; and Multiple Clinical Case Studies. The educational library currently contains over 50 CME hours and 25 Contact Hours for nurses.

The web-based audit tool contains a powerful clinical reporting feature that has been extremely well received by emergency practitioners. The EMRI audit has resulted in remarkable improvements in clinical care and documentation in many emergency departments.

For more information about this unique, cutting edge program,
contact TSG at **1-866-MedRisk** (**1-866-633-7475**).