THE SULLIVAN GROUP

TSG NEWSLETTER

SAVING LIVES - REDUCING RISK

From The Editor

You have a critically ill patient in your ED. Your hospital does not have the resources to stabilize and manage this patient's problem; transfer for a higher level of care is required. Under EMTALA, what level of treatment is required prior to transfer? What standard will the Courts apply? Must the care provided be the best care possible? Must it meet the 'standard of care'? The First Federal Circuit recently addressed this specific issue.

It has been some time since we visited EMTALA in this newsletter. The First Federal Circuit recently evaluated the care that is required prior to transfer of an unstable patient to a receiving hospital. In another EMTALA development, the Supreme Court recently decided not to address a key issue that is making its way around the Federal Circuits. We will explore both in this edition of the TSG Newsletter ■

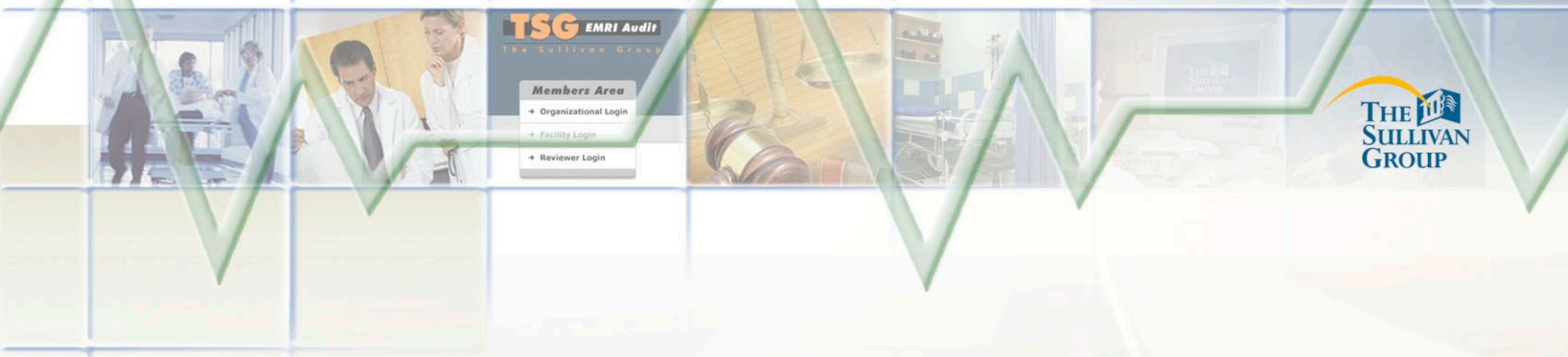
In This Issue...

What Care Is Required Before Transfer?

The first case addresses the requirements necessary before transferring an "unstable" patient to a receiving hospital.

Puerto Rico is in the First Federal Circuit and has been a hotbed of EMTALA litigation for years. Some of the most interesting fact patterns and EMTALA precedent come from that jurisdiction. In April of this year, the First Circuit affirmed a summary judgment against a plaintiff who based an EMTALA lawsuit on an alleged failure to provide optimal treatment prior to transfer.

In so holding, the Court rejected the plaintiffs' contention that an EMTALA violation arises when a hospital fails to deliver the



best treatment, whatever it may be in a given case, before transfer.

In this case, the plaintiffs sued Centro Medico del Turabo d/b/a Hospital HIMA San Pablo Fajardo in Puerto Rico, arguing that it improperly transferred their son Jose Ramos Lopez, who later died, to another hospital in violation of EMTALA. Ramos presented to the hospital with a history of abdominal problems and anemia. He was experiencing abdominal pain; he subsequently vomited blood and was diagnosed with gastrointestinal bleeding.

The hospital did not have a gastroenterologist, so the emergency physician arranged transfer to another hospital. The emergency physician documented "gastroenterologist" as the reason for the transfer. The patient died at the receiving hospital.

Under EMTALA, a physician must certify that the benefits of the transfer outweigh the risks. The Appeals Court held that the hospital satisfied this requirement because the transferring physician's "gastroenterologist" summary statement indicated that the benefit of providing Ramos with specialized treatment that was unavailable at the hospital outweighed the risk of transport.

Turning to the main issue in this case - What type of treatment is required prior to transfer? - the Court had to turn to the EMTALA statute. In making decisions that relate to a particular statute, the Courts first look at the plain language of the statute. The key issue here, and the Court's focus, was whether the hospital provided "the medical treatment within its capacity which minimized the risks to the individual's health." That begs the question, "What is medical treatment within its capacity which minimizes the risks to the individual's health?" This phrase requires interpretation in order to be fairly applied in this case and to subsequent cases that address the same issue.

Other Circuits that have addressed the issue have applied the same logic utilized for the "appropriate medical screening" language. A hospital violates EMTALA if it fails to follow its standard procedures, not by providing allegedly faulty treatment.

Thus, the current precedent in the Federal Circuits on this issue is that hospitals should follow policy or standard procedure; in other words, treating a patient according to policy or protocol or as you would treat any other patient under similar circumstances. The corollary is that if policy and procedure are not followed or treatment for this individual is 'different' than for others, then there may be a basis for a claim. That does not mean that every Circuit must follow suit, as will be apparent from the next case.

The First Circuit called the plaintiffs' position on this point "untenable." It noted that a "best treatment" interpretation "would create a federal malpractice cause of action" that would allow an unstabilized patient to sue in Federal Court any time he or she did not receive the correct care prior to transfer.

At a minimum, the First and Tenth Circuits have now taken the same position on this issue, and this is good news. Others are likely to follow. This is a correct interpretation of this provision, and is supportive of the excellent care typically provided by emergency physicians, nurses and hospitals. The alternative, forwarded by the plaintiffs in this case, is indeed untenable[1] ■

1 Ramos-Cruz v. Centro Medico Del Turabo, No. 10-1203 (1st Cir. April 8, 2011).

The U.S. Supreme Court Refuses To Hear EMTALA Case

When a patient presents to an emergency department with an emergency medical condition, EMTALA requires that the hospital provide a medical screening examination and stabilizing treatment for an emergency medical condition. This is old news. What's

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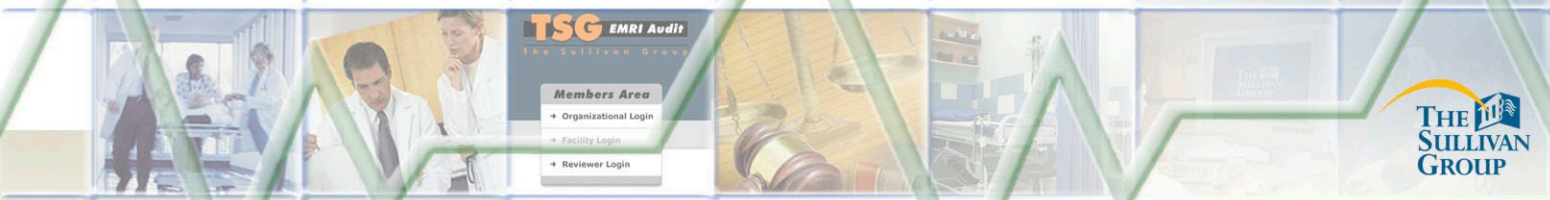
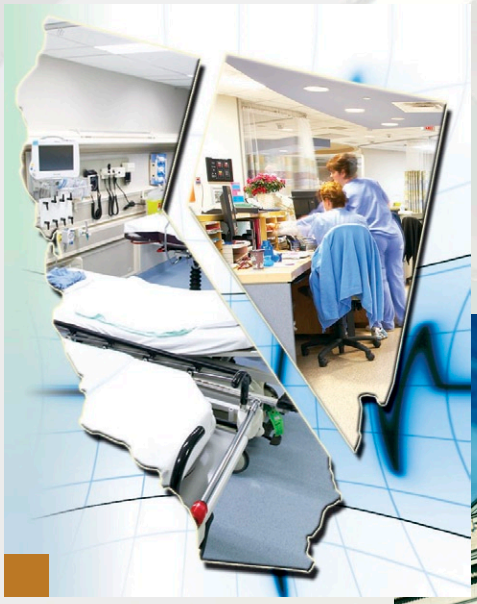


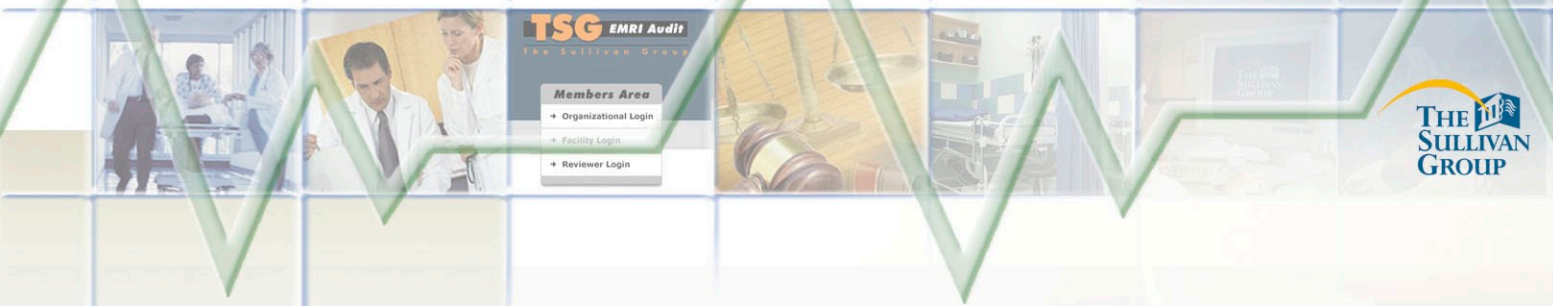
newsworthy is that there is a significant controversy brewing among the Federal Circuit Courts regarding whether EMTALA continues to apply following admission to the hospital. The result is that hospitals in different states may have very different EMTALA obligations. This is an untenable situation that needs resolution, and we need the U.S. Supreme Court or Congress to do something about it.



When an emergency medical condition is detected, a hospital may decide to admit the individual as an inpatient for further treatment. Whether the stabilization requirement continues to apply to patients after they have been admitted is a disputed issue. The reason that a dispute is possible is because the EMTALA statute specifically addresses the stabilization issue related to the transferred patient, but does not specifically address the stabilization requirement for patients admitted to the hospital. Generally, the Courts follow the plain language of the statute, but there is no plain language on this particular issue. Therefore, the Courts have to review the facts of a particular case and interpret what it thinks Congress intended.

The Courts will often defer to the interpretation by the relevant regulatory agency regarding the issue; in this case, the relevant regulatory agency is CMS. In this case, the Sixth Federal Circuit declined to follow the CMS interpretation and created this controversy between the Circuits.

This issue has come up in several Circuits. Because the statute only defines "stabilization" in the context of transfers, the Fourth,



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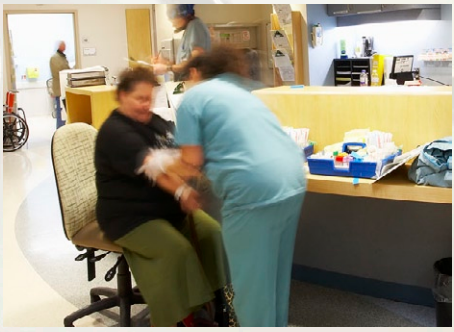
Ninth and Eleventh Circuits have held that a hospital has no stabilization duties that are enforceable under EMTALA once an individual has been admitted. That is consistent with the 2003 CMS and more recent interpretation of the law.[2]

In August of 2008, the Department of Health and Human Services further clarified its position by stating that EMTALA does not apply to an individual who has been screened and admitted at one hospital but requires a transfer to a second hospital that has specialized facilities.[3]



The current regulations clearly state that once the individual has been admitted as an inpatient in one hospital, other specialized hospitals do not continue to have a duty to accept a transfer under EMTALA.[4]

Despite the promulgation of these rules, the Sixth Circuit has continued to hold that the mere admission of an individual without further treatment does not satisfy EMTALA.[5] In Moses v. Providence Hospital, the Court found CMS's regulations to be

2 42 C.F.R. § 489.24(d)(2).
3 73 Fed. Reg. 48,656-61.
4 42 C.F.R. § 489.24(f)(2).
5 Moses v. Providence Hosp. & Med. Ctrs., Inc., 561 F.3d 573, 582 (6th Cir. 2009), cert. denied, Providence Hosp. v. Moses, 2010 U.S. LEXIS 5301 (June 28, 2010).

contrary to the plain language of the statute. Therefore, the CMS regulations were not entitled to deference.

In Moses, the issue was whether EMTALA applied to the discharge of a psychiatric patient from the hospital inpatient setting many days after he had been admitted through the emergency department for stabilizing care. After discharge, the patient went home and later murdered his wife, so the family sued Providence Hospital under EMTALA for failure to stabilize the patient prior to discharging him home. Under EMTALA, all discharges from the hospital are legally defined as "transfers," regardless of whether the discharge is from the ED or inpatient setting. Thus, the plaintiff's claim was for "failure to stabilize the patient prior to transfer" as required by EMTALA.

The Court relied upon language in EMTALA that prohibits hospitals from releasing patients with emergency medical conditions without providing treatment to stabilize the condition. According to the Court, the CMS regulations would permit hospitals to avoid EMTALA liability by simply admitting and immediately discharging patients without providing any treatment. The Court found such a construction to be unreasonable and contrary to the language of the statute.

The defendant hospital in Moses petitioned the Supreme Court for review, but the Court declined to hear the case. Why would the Supreme Court decline the case when resolving discrepancies between the Federal Circuits is one of its key responsibilities? A brief written for the Supreme Court by the Solicitor General for this matter indicates that: 1) CMS has already addressed this issue, that the CMS position is reasonable, and that this position should be deferred to; and 2) CMS would be reconsidering the matter in the near future. So why didn't the Supreme Court review the case? It is not completely clear.

Perhaps the Court considered the following issues from the Moses case. The Sixth Circuit's decision in Moses relied in part on the fact that the underlying hospital visit occurred in 2002, before CMS had promulgated its regulations on inpatient status. Additionally, the Court noted that CMS's regulations did not expressly indicate an intent to apply retroactively. The Supremes may be waiting to see what happens in subsequent Sixth Circuit cases where the fact pattern occurred after CMS adopted its current position.

The result of this precedent-setting Sixth Circuit decision is that Federal District Courts in the Sixth Circuit (Kentucky, Michigan, Ohio, Tennessee) are likely to follow suit. At least one Federal District Court in the Sixth Circuit has cited Moses for the proposition that states, "EMTALA imposes an obligation on a hospital beyond simply admitting a patient with an emergency medical condition to an inpatient care unit."[6]

It will be necessary to adopt a wait-and-see posture. In the meantime, the states in the Sixth Circuit are following a very different path, one that is not consistent with the CMS regulations and Interpretive Guidelines. This may cause significant confusion for admitting hospitals in those states and for those facilities that are called upon to receive patients for transfer from those hospitals ■

Thank You.

6 Lilly v. Harper Hosp Assocs, 2009 U.S. Dist. LEXIS 121405 (E.D. Mich. Dec. 3, 2009) Finding was that defendant hospital did not violate EMTALA where patient was admitted for treatment and subsequently died at the hospital.

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