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EMTALA from A to Z

Part 2

Your Speaker

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Objectives

- Explain the on-call requirements for doctors covered by EMTALA.
- Explain new and revised standards, regulations, and laws put forth by CMS, TJC and the federal government.
- Evaluate compliance requirements and penalties.

Outline

- Historical background
- EMTALA overview
- Screening
- Stabilization
- Transfer
- Public health emergencies
- No delay in examination or treatment
- Enforcement
- Defenses
- Whistle blower protections
- What the investigator will request
- What a hospital with a DED must do

Part 2, 10/30/15

- Stabilization
- Transfer

Stabilization (b)

- **(1) In general** If any individual (whether or not eligible for benefits under this subchapter) comes to a hospital and the hospital determines that the individual has an emergency medical condition, the hospital must provide either—
- **(A)** within the staff and facilities available at the hospital, for such further medical examination and such treatment as may be required to stabilize the medical condition, or
- **(B)** for transfer of the individual to another medical facility in accordance with subsection (c) of this section.

Duty to Stabilize

"If any individual (whether or not eligible for benefits under this subchapter) comes to a hospital and the **hospital determines that the individual has an emergency medical condition**, the hospital must provide…" (b)(1)

- Extends to "only those EMCs that staff **detects**;" "hospital does not violate EMTALA if it fails to detect or if it misdiagnoses an emergency condition."
  - *Bryant*[*v. Adventist Health System/West* 289 F.3d 1162 (9th Cir. 2002); *Baker v. Adventist Health*, *Inc.,* 260 F.3d 987(9th Cir. 2001)
  - *Leimbach v. Haw. Pac. Health*, *supra*
  - *Cruz-Vázquez v. Mennonite General Hosp., Inc*. 717 F.3d 63 (1st Cir. 2013)
  - *Phillips v Hillcrest Med. Ctr*., 244 F.3d 790, (10th Cir 2001), *cert den* 535 US 905, *reh den* 535 U.S. 1043 (2002)
  - *Vega-Feliciano v. Doctors' Ctr. Hosp., Inc*., 2015 U.S. Dist. LEXIS 55845 (DPR 2015).

Required for a Stabilization Claim

- P must show plaintiff
  - "(1) had 'an emergency medical condition;
    (2) the hospital actually knew of that condition; [and
    (3) the patient was not stabilized before being transferred.'"
  - *Torretti v. Main Line Hospitals, Inc*., 580 F.3d 168, 178 (3d Cir. 2009) (quoting *Baber v. Hosp. Corp. of Am*., 977 F.2d 872, 883 (4th Cir. 1992))

No Duty to Stabilize a Condition Not Diagnosed

"As to a failure to stabilize, the allegations regarding the…ER visit are insufficient because Ds were obligated to stabilize only the medical conditions they **actually diagnosed**, **not what P alleges they should have identified**. *See Eberhardt*, 62 F.3d at 1259. Although P asserts that Ds should have detected his necrotizing fasciitis,…P does not allege that Ds did diagnose him with necrotizing fasciitis….Rather, Plaintiff was only diagnosed with a viral infection and an ankle sprain…for which he was treated…Again, EMTALA is not a medical malpractice statute, and **failing to correctly diagnose Plaintiff's illness does not give rise to liability** under § 1395dd. *See Bryant*, 289 F.3d at 1165.

- *Leimbach v. Haw. Pac. Health*, 2015 U.S. Dist. LEXIS 95397 (D. Haw. 2015)(necrotizing fasciitis)
- *Perry v. Owensboro Health, Inc*., 2015 U.S. Dist. LEXIS 93688 (W.D. Ky. July 16, 2015)(death following non-healing wound)
- Matta-Rodríguez v. Ashford Presbysterian Cmty. Hosp., 60 F. Supp. 3d 300, 2014 U.S. Dist. LEXIS 98251, 2014 WL 3592087 (D.P.R. 2014) (lacerated bile duct after cholecstectomy)

Actual Knowledge Required

- Merely knowing facts sufficient to put hospital on **notice** of EMC insufficient
  - *Owensboro Health, Inc*., 2015 U.S. Dist. LEXIS 93688 (W.D. Ky. 20I5)(hypertension and leukocytosis)
- Mere **suspicion** not enough
  - *See Camp*, 983 S.W.2d at 880; *Casey v. Amarillo Hosp. Dist*., 947 S.W.2d 301, 304 (Tex. App. 1997)
- Knowledge of **doctors**, but **not of nurses**, **imputed** to hospital
  - *Camp*, 983 S.W.2d at 881; *Casey*, 947 S.W.2d at 304-05
    - A curious reversal from tort law

Actual Knowledge Required

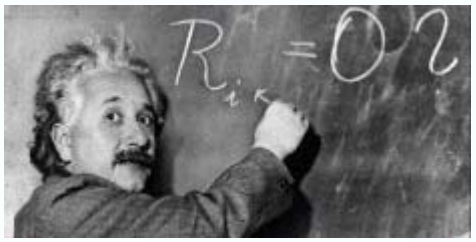
Agreement

- *Taylor*, 26 F. Supp. 3d at 650
- *Moses v. Providence Hosp. & Med. Ctrs., Inc.*, 561 F.3d 573, 585 (6th Cir. 2009) (citing *Roberts*)
- *Cleland*, 917 F.2d at 271(intussusception mistaken for flu)
- *Urban ex rel. Urban v. King*, 43 F.3d 523, 526 (10th Cir. 1994)
- *Owensboro Health, Inc*., 2015 U.S. Dist. LEXIS 93688 (W.D. Ky. 20I5)
- *Guzman v Mem'l Hermann Hosp. Sys*. (S.D. Tex. 2009) 637 F. Supp. 2d 464, *motion den as moot* (S.D. Tex. 2009) 2009 US Dist LEXIS 79179(bacterial infection taken for viral)
- *Stringfellow v. Oakwood Hosp. & Med. Ctr*., 409 F. Supp. 2d 866 (E.D. Mich. 2005)(missed aortic dissection)

Constructive Knowledge Not Enough

- Hospital's actual knowledge of pain, fever, nausea, vomiting, diarrhea, hypertension and leukocytosis associated with non-healing surgical wound does not establish it knew of an EMC
  - *Perry v. Owensboro Health, Inc*., 2015 U.S. Dist. LEXIS 93688 (W.D. Ky. 2015)

Actual Knowledge Demonstrated



Patient admitted for fever, pain on swallowing, and difficulty breathing, and, though **CT scan confirmed probable throat abscess**, on admission, treatment was limited to medication, with no further testing, and patient was discharged from hospital but thereafter required emergency surgery on same day; complaint alleged that patient suffered from parapharyngeal space abscess when arriving at hospital, and hospital personnel knew of condition

- *Mazurkiewicz v Doylestown Hosp*., 223 F. Supp. 2d 661 (E.D. Pa. 2002)(so claim lies)

Ongoing Symptoms Not Enough

- Without dx EMC, as where D hospital's ERP determined that P patient's condition was non-emergent, no duty to stabilize before discharge
- Patient's statement to nurse during discharge that he was still in same amount of pain was immaterial, because he had **already been diagnosed**, correctly or not, with benign headache, and pain alone could not impute actual knowledge of emergency medical situation under 42 USCS § 1395dd(e)(1)
  - *Stiles v. Tenet Hosps. Ltd.*, 2012 US App LEXIS 20894 (5th Cir. 2012) (unpublished)

Duty to Stabilize, 2

- No duty to stabilize EMC patient who is not **transferred**
  - *Harry v. Marchant,* 291 F.3d 767 (11th Cir. 2002)
- Patient with ruptured gall bladder has no claim because stabilization requirement could not be met:
  - Patient was admitted as inpatient, and treated for over a month
  - Thus, he was **never dumped, transferred, or discharged**
  - Whether treatment was deficient or administered negligently was not controversy covered by EMTALA
    - *Benitez-Rodriguez v. Hosp. Pavia Hato Rey*, Inc., 588 F. Supp. 2d 210 (D. P.R. 2008)

Required: Stabilization, Not Cure

"EMTALA requires only that a hospital stabilize an individual's medical condition and not that it cure the patient."

- *Clark*, 657 So. 2d at 747
- Accord: *Green v. Touro Infirmary*, 992 F.2d 537, 539 (5th Cir. 1993); *Brooker v. Desert Hosp. Corp*., 947 F.2d 412, 415 (9th Cir. 1991); *Torres Nieves v. Hospital Metropolitano*, 998 F. Supp. 2d 127, 133 (D.P.R. 1998); *Watts*, 962 S.W.2d at 108

May D/C Stable Patient

- No violation when hospital admits EMC patient, but discharges him **before full recovery**, so long as patient's medical condition has **stabilized**
- Statute is not intended to require hospital to bring patients to complete recovery, but only to give them ER treatment notwithstanding indigence
  - *Thornton v. Southwest Detroit Hosp.,* 895 F2d 1131, 104 ALR Fed 157 (6th Cir. 1990)

Stabilization: Disparate Treatment Not Necessary

- Transfer of pt s/p undiagnosed post-op hematoma (after spinal cord stimulator implant) could violate EMTALA with or without a showing of disparate treatment
  - *Quinney v. Phoebe Putney Mem. Hosp*., 325 Ga. App. 112, 751 S.E.2d 874 (Ga. Ct. App. 2013)

Duration of Duty

- Duty continues until patient is stabilized for transfer, released or admitted
  - *Harry v Marchant*, 237 F.3d 1315 (11th Cir. 2001) *vacated, reh, en banc, gr*, 259 F.3d 1310 (11th Cir. 2001) and *en banc, reinstated, in part, mod, in part*, 291 F3d 767 (11th Cir 2002)
  - "…stabilization requirement normally ends when a patient is **admitted**..."
    - *Bryant v. Adventist Health System* 289 F.3d 1162, 1167 (9th Cir. 2002)(failure to dx lung abscess at presentation; failure to stabilize inpatient)

Duration of Duty, 2

- "[O]nly in the immediate aftermath of the act of admitting [P] for emergency treatment and while [the hospital] considered whether it would undertake longer-term full treatment or instead transfer the patient..."
  - *Bryan v. Rectors and Visitors of Univ. of Virginia*, 35 F.3d 349, 352 (4th Cir. 1996)(dismissed claim for hospital's non-resuscitation order issued after it had treated the patient x 12 days; otherwise ED patients would have greater rights than others)
- "[O]nce a patient is found to suffer from an EMC in the ER, she cannot be discharged until the condition is stabilized, regardless of whether the patient stays in the emergency room."
  - *Thornton*, 895 F.2d at 1134

Duration of Duty: Boarders

- For EMC, hospital must provide stabilizing treatment, even if the individual is **awaiting admission** in DED. Once the individual has been **stabilized**, EMTALA obligations **end**
- For EMTALA purposes, individuals in DED who are admitted but "boarded" are **inpatients** if, generally, they have been admitted with the expectation that they will remain at least overnight and occupy beds in the hospital.
  - Clarifying Policies

Effect of Admission

- At admission: stabilization requirement ends; statute generally ceases to apply
  - *Bryant*, 289 F.3d at 1168
  - From then on, "state tort law provides a remedy for negligent care”
    - *Id*. at 1169. *Leimbach v. Haw. Pac. Health*, 2015 U.S. Dist. LEXIS 95397 (D. Haw. 2015)
    - Accord, Clarifying Policies; see also, CoPs
  - **Discharge planning CoP**, 42 CFR 482.43: Must satisfy procedural requirements to show adequate consideration given to patient’s post-discharge care needs

Admission Extinguishes EMTALA Stabilization Claims

- Admission extinguishes any EMTALA claim
  - *Alvarez-Torres v Ryder Mem. Hosp., Inc*., 576 F. Supp. 2d 278 (DPR 2008), *aff'd* 582 F3d 47 (1st Cir. 2009)
  - *Bryant v. Adventist Health Sys./West*, 289 F.3d 1162,1167 (9th Cir. 2002)
  - *Leimbach v. Haw. Pac. Health*, 2015 U.S. Dist. LEXIS 95397 (D. Haw. 2015)
  - *Lopez v. Contra Costa Reg'l Med. Ctr*., 2014 U.S. Dist. LEXIS 27663 (N.D. Cal. 2014) (death following childbirth)
  - *James v. Regional,* 2012 U.S. Dist. LEXIS 67763 (E.D. Mo.2012)(psychotic patient discharged shortly after admission for fighting with another patient).
  - *Contra, Liles v. TH Healthcare, Ltd*., 2014 U.S. Dist. LEXIS 62171(E.D. Tex. 2014)(relying on older case law)

Admission is a Defense Unless There's Subterfuge

- Hospitals cannot escape EMTALA liability by ostensibly "admitting" a patient, with no intention of treating, and then discharging or transferring without stabilizing
  - *Bryant v Adventist Health System/West*, 289 F3d 1162 (9th Cir. 2002)
  - *Mazurkiewicz v Doylestown Hosp*. 305 F. Supp. 2d 437 (E.D. Pa. 2004)
    - Accord, Clarifying Policies

Admission Does **Not** Extinguish EMTALA Claims

- Pt in ICU x 10d; transferred to floor X 11d. Total stay: 3w. Lost EMTALA claim because her condition was already stabilized at D/C, but court wrote that liability under EMTALA "does not always stop when a patient is wheeled from the ER into the main hospital" and that emergency care required until the patient is stabilized
  - *Thornton v. Southwest Detroit Hospital*, 895 F.2d 1131, 1135 (6th Cir. 1990)(Otherwise hospitals would admit and then d/c immediately)(**DICTA**)
- Hospital's duty does not end on admission but on treatment and stabilization of EMC, regardless how long that takes
  - *Moses v. Providence Hospital and Medical Centers, Inc*., 561 F.3d 573 (6th Cir. 2009)
- Screening requirement applies to individuals who seek assistance at ER, but stabilization requirement obliges hospitals to stabilize individuals **whenever** emergency conditions are **detected**
  - *Lopez-Soto v. Hawayek*, 175 F.3d 170, 175 (1st Cir. 1999)

Stabilizing Psych Patients

- Psychiatric patients are "stable" when **protected and prevented from injuring** or harming **self or others**
  - Stabilization: issue of fact where hospital released P's psychotic wife after social worker recommended hospitalization
    - *Thomas v. Christ Hosp. & Med. Ctr*., 328 F.3d 890 (7th Cir 2003)
- **Restraints**: Administration of chemical or physical restraints for transfer may **stabilize** a psychiatric patient for a period of time and remove immediate EMC
  - Underlying medical condition may persist
  - If not treated, patient may experience exacerbation of EMC
  - Practitioners should use great care when determining if medical condition is stable after administering restraints
    - Interpretive Guidelines §489.24(d)(1)(i)

Failure to Stabilize Claims: Experts Needed

- **Expert required:** whether hospital provided "treatment that medical experts agree would prevent the threatening and severe consequences of [pt's EMC] while…she was in transit."
  - Unlike failure to screen claim
    - *Burditt,* 934 F.2d at 1369; *Delaney v. Cade*, 986 F.2d 387 (10th Cir. 1993); *Barris v. County of Los Angeles*, 20 Cal. 4th 101, 972 P.2d 966, 83 Cal. Rptr. 2d 145 (1999)

Failure to Stabilize Claims: Experts Needed, 2

- "…P [must] identify the symptoms that different screening procedures **would have found** and that would have **alerted Ds** to the need for immediate medical attention…And such allegations may not be within the general knowledge of P, raising the possible need for expert input, even at this pleading stage..."
  - *Leimbach v. Haw. Pac. Health*, 2015 U.S. Dist. LEXIS 95397 (D. Haw. 2015)
- **Exception**: treating physician sent pt home to deliver a fetus he had determined to be deceased *in utero*, rather than providing further treatment in the hospital
  - Morin v. Eastern Maine Medical Center, 779 F.Supp.2d 166 (D. Me. 2011)

P Must Show Causation

Claim sounds in tort, so causation necessary

- *Romine v. St. Joseph Health Sys*., 541 Fed. Appx. 614, 2013 U.S. App. LEXIS 21926, 2013 WL 5750095 (6th Cir. Ky. 2013)
- *Accord, Cisneros v. Metro Nashville Gen. Hosp*., 2013 U.S. Dist. LEXIS 165592 (M.D. Tenn. 2013)(blindness OD caused by undiagnosed neovascular glaucoma 2°diabetes); *James v. Regional*, 2012 U.S. Dist. LEXIS 67763 (E.D. Mo. 2012)(no demonstration that harms to psychotic patient were caused by his allegedly improper discharge)

Alleging failure to do diagnostic incision and ultrasound, without what these would have revealed, is fatal to claim

- *Leimbach v. Haw. Pac. Health*, 2015 U.S. Dist. LEXIS 95397 (D. Haw. 2015)

Suicide **>1m post last visit** not actionable for want of causation

- *Tolton v. American Biodyne*, 48 F3d 937 (6th Cir 1995)

Failure to f/u with PCP as instructed was a **superseding cause** of the patient's MI three weeks post-screening

- *Williams*, 34 F.3d at 696

Failure to Stabilize Claims Require **Transfer**

- Plaintiffs failed to establish "stabilization" claim under EMTALA (b) and (c) by failing to allege that hospital employee transferred patient outside of hospital or discharged him
  - *Alvarez-Torres v. Ryder Mem. Hosp., Inc.,* 576 F. Supp. 2d 278 (D.P.R. 2008), *affd* 582 F.3d 47 (1st Cir 2009).
- Where claim is based on response to emergency condition, but no transfer or discharge occurs, stabilization requirement under 42 USCS § 1395dd(b) **does not apply**
  - *Benitez-Rodriguez v. Hosp. Pavia Hato Rey, Inc*., 588 F. Supp. 2d 210 (D.P.R. 2008).
  - Accord, *Harry v. Marchant,* 291 F.3d 767, 15 FLW Fed C 590 (11th Cir. 2002); *Maldonado-Rodriguez v. St. Luke's Mem. Hosp., Inc*., 940 F. Supp. 2d 30, 2013 U.S. Dist. LEXIS 58053, 2013 WL 1715492 (D.P.R. 2013)

Stabilization and **On-Call Requirements**

- CoP: hospitals must maintain list of physicians on call for duty after initial exam to provide treatment necessary to stabilize EMC
  - Section 1866(a)(1)(I)(iii), Social Security Act
- **Treating MD** determines whether on-call MD should come to ED
- Treating MD may **communicate** with on-call MD in various ways
  - Survey and Certification Letter S&C–07–23 (June 22, 2007)
- If hospital calls listed MD to provide emergency screening or treatment and he either **fails or refuses** to appear within a reasonable time, hospital and that physician may be in violation
  - 1867(d)(1)(C) of the Act; Clarifying Policies

Stabilization and On-Call Requirements, 2

- Physicians need not be on call at all times
- Hospital must have P&P for when a particular specialty is not available or on-call MD cannot respond
  - May elect to permit on-call physicians to schedule **elective surgery**
    - §489.20(r)(2); § 489.24(j); Clarifying Policies; CMS State Operations Manual Appendix V, page V-15, Tag A404
- List adequacy: CMS will consider all relevant factors, including
  - Number of **MDs on staff**
  - **Other demands** on these physicians
  - **How often** patients typically **require** services of on-call physicians
  - **Provisions** for when MD **not available** or on-call MD cannot respond
- Hospitals that cannot maintain full-time on-call coverage in specific specialties should **advise local EMS** staff of times when certain specialties are not available, thus minimizing transfers
    - Clarifying Policies

Stabilization and On-Call Requirements, 3

- Hospitals should have **flexibility** to manage on-call physician coverage in a manner that maximizes patient stabilizing treatment as efficiently and effectively as possible
- When on-call physician is simultaneously on-call at **>1 hospital** in the area, all hospitals involved must know the schedule, as each independently has an EMTALA obligation
- Hospitals must have **P&P** to follow when on-call MD is simultaneously on call at another hospital and not available
  - P&P may include, but are not limited to, procedures for back-up on-call physicians, or implementation of an appropriate EMTALA transfer according to §489.24(d)
    - Survey and Certification Letter No. S&C-02-35 (June 13, 2002)

Community Call: Plan Requirements

- Delineate when each hospital is responsible for coverage
  - Not all hospitals in community need participate
- Define specific geographic area plan applies to
- Representative of each hospital participating should sign
- Local, regional EMS protocol for call arrangements
- Statement specifying that even if an individual arrives at a hospital not on-call, that hospital still must provide MSE, stabilization within its capability, and proper transfers
- Participating hospitals to **assess plan annually**
  - § 489.24(j); Interpretive Guidelines §489.20(r)(2), §489.24(j); 73 (161) Fed. Reg. 48663 **(**August 19, 2008)

Community Call: Plan Requirements, 2

- "An on-call list of physicians who are on the hospital's medical staff, or who have privileges at the hospital, or who are on staff or have privileges at **another hospital** participating in a formal community call plan in accordance with § 489.24(j)(2)(iii) **available to provide treatment** necessary after the initial examination to stabilize individuals with EMCs who are receiving services required under § 489.24 in accordance with the resources available to the hospital."
  - 42 CFR § 489.20(r)(2)
- On-call **physician need not travel** from his hospital to patient's. Plan allows appropriate transfers to the hospital providing the specialty on-call services pursuant to the plan
  - State Operations Manual, Appendix V – Interpretive Guidelines

On-Call Requirements in Specialty Hospitals

- Existing regulations implementing the requirement for an on-call list make it clear that this requirement does not apply to any hospital other than one with a **DED**
  - 42 CFR §489.20(r)(2); Clarifying Policies

On-Call Requirements Ignored

- Act provides penalties for physicians who negligently violate a requirement of §1867, including on-call physicians who refuse to appear
  - EMTALA violation, on-call coverage: surveyors and CMS regional office staff will review facts to see that hospitals acting in good faith to provide coverage are not penalized for individual physician' failures to fulfill their obligations
- Hospitals facing physicians' refusals to assume on-call responsibilities could suspend, curtail, or revoke their privileges
  - §1867(d)(1)(B) of the Act; Clarifying Policies

Stabilization by PAs

- PA may be the appropriate practitioner to respond to a call from an ED or other hospital department that is providing EMTALA-mandated screening or stabilization
- Based on individual's medical needs and hospital's capabilities, on-call MD to decide whether to respond in person or through PA
- Appropriate only if consistent with applicable State scope of practice laws and hospital bylaws, rules, and regulations
  - Clarifying Policies

Analyzing (a) v. (b) and (c): DISJUNCTIVE Approach

- Breach of duty to screen under subsection (a) and of the duty to treat and stabilize or appropriately transfer under subsection (b) are **two distinct causes of action**
  - 6th Cir, 1st Cir., Virginia Supreme Court
  - **Regardless of patient's location**, must stabilize or appropriately transfer inpatient with an EMC
    - *Thornton v. Southwest Detroit Hospital*, 895 F.2d 1131 (6th Cir. 1990) (change in wording between the screening requirement for patients that come to a "hospital **emergency room**" in subsection (a) and the stabilization requirement in subsection (b) that applies to the "**hospital**" supports the disjunctive approach)
      - Accord, *McIntyre v. Schick*, 795 F. Supp. 777, 780 (E.D. Va. 1992)

DISJUNCTIVE Approach, 2

- TC: For her respiratory distress, newborn had come to hospital not through ER but via OR
  - Stabilization and transfer obligations did not apply
- Appeal: **reversed**
  - Mothers usually give birth on L&D, not ERs. Dumping is not limited to ERs, so forbidding it in any hospital patient with unstabilized EMC furthers EMTALA's purpose
  - Under a conjunctive approach, "comes to a hospital," §b, would be meaningless. That interpretation would mean replacing "comes to a hospital" with "comes to the ED," §a
    - *Lopez-Soto v. Hawayek*, 175 F.3d 170 (1st Cir. 1999)

Disjunctive Approach, 3

- Hospital may violate subsection (b) or (c) even though the patient was not present in ER and regardless of the screening exam received by the patient
  - *Lopez-Soto v. Hawayek*, 175 F.3d 170, 173 (1st Cir. 1999)
  - *Smith v. Richmond Mem'l. Hosp*., 243 Va. 445, 451-52, 416 S.E. 2d 689, 692 (1992)
  - *Loss v. Song*, No. 89C 6952 1990 U.S. Dist. LEXIS 13667 (N.D. Ill. 1990)
  - *Reynolds v. Mercy Hosp*., 861 F. Supp. 214, 222 (W.D.N.Y. 1994)
  - *Helton v. Phelps County Reg'l Med. Ctr*., 794 F. Supp. 332, 333-34 (E.D. Mo. 1992)

DISJUNCTIVE Approach, 4

- **Transfer** section, unlike the stabilization section, has **no knowledge requirement**…[U]nder a literal reading of the transfer section, a hospital may not transfer a patient…without stabilizing his EMC, unless one of the exceptions applies, none of which addresses a hospital's lack of knowledge about the condition. Thus, a reading of this section that fails to incorporate the knowledge requirement of the stabilization section "leads inescapably to the conclusion that stabilization is required if the patient 'has an EMC' **even if that condition is not diagnosed**."
  - *Carodenuto v. New York City Health & Hospitals Corp.*, 593 N.Y.S.2d 442, 446 (1992)(summary judgment denied where head trauma case was discharged and readmitted; liability for failure to stabilize may lie even though EMC not originally diagnosed)

CONJUNCTIVE Approach

- Subsections (a)-(c) should be read in the conjunctive, and therefore subsections (b) and (c) apply to only those patients who first appeared in the ER, not just the hospital
  - *James v. Sunrise Hospital*, 86 F.3d 885, 889 (9th Cir. 1996)
  - *Baber v. Hospital Corp. of America,* 977 F.2d 872, 880 (4th Cir. 1992)
  - *Urban v. King*, 43 F.3d 523, 525-27 (10th Cir. 1994)
  - *Gatewood v. Washington Healthcare Corp.,* 290 U.S. App. D.C. 31, 933 F.2d 1037, 1041 (D.C. Cir. 1991)

CONJUNCTIVE Approach

- Congress did not use "and" or "or" to connect subsections (a), (b), and (c), so (c)'s **transfer duty deals with people who have EMCs under subsection (b)**. Under (b), the transfer must be "in accordance with subsection (c)," so (c) regulates transfers made in accordance with (b). Subsection (c)'s transfer provisions depend on whether a physician "is not physically present in the ER," referring to decisions made there. It would be illogical for the doc's physical presence in the ER to affect transfers from other hospital departments and locations. Therefore, **transfer restrictions apply only when an individual "comes to the ER,"** and after "an appropriate MSE," "the hospital determines that the individual has an EMC."
  - *James,* 86 F.3d at 886 (no case where at discharge after 5 day stay hospital recognized no EMC)

Stabilization: **Refusal to Consent** to **Treatment** (b)(2)

- A hospital is deemed to meet the requirement of paragraph (1)(A) [stabilization] with respect to an individual if the hospital **offers** her the further medical exam and treatment described in that paragraph and **informs** her (or a person acting on her behalf) of the **risks and benefits** to her of such examination and treatment, but she (or a person acting on her behalf) **refuses** to consent to the exam and treatment. The hospital shall **take all reasonable steps** to secure the individual's (or person's) written informed consent to refuse such examination and treatment.

Refusal to Consent to **Transfer** (b)(3)

- A hospital is deemed to meet the requirement of paragraph (1) with respect to an individual if the hospital **offers to transfer** the individual to another medical facility in accordance with subsection (c) of this section and **informs** the individual (or a person acting on the individual's behalf) of the risks and benefits to the individual of such transfer, but the individual (or a person acting on the individual's behalf) refuses to consent to the transfer. The hospital shall take all reasonable steps to secure the individual's (or person's) written informed consent to refuse such transfer.

EMTALA Stabilization Rule Trumps Ethics

- Must provide stabilizing treatment even when it would violate the hospital's ethical principles or is contrary to its standard practices
  - *In re Baby K*, 16 F.3d 590, 596-97 (4th Cir. 1990), cert. denied 513 U.S. 825 (1994)(anencephalic infant)
- Lawsuit claiming a violation of EMTALA's stabilization provision was filed after a Louisiana hospital stood by its ethical principles and refused to perform an abortion
  - Joe Gyan, Jr., "Heart Patient Sues Hospital, State Officials for Denying Abortion," *Baton Rouge Advocate*, Mar. 12, 1999, at 4-B126

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- Enforcement
- Defenses
- Whistle blower protections
- What the investigator will request
- What a hospital with a DED must do

Part 2

- Stabilization
- Transfer

Transfer Claims (c)(1)

- If an individual at a hospital has an EMC which has not been stabilized…the hospital may not transfer the individual unless—
- **(A)**
  - **(i)** the individual…after being informed of the hospital's obligations ….and of the risk of transfer, in writing **requests** transfer…,
  - **(ii)** a physician…has signed a **certificatio**n that based upon the info available…the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks… and, in the case of labor, to the unborn child from effecting the transfer, or
  - **(iii)** if a physician is not physically present…a **QMP**…has signed a **certification** described in clause (ii) after a **physician**…in consultation with the [QMP], has made the determination and subsequently countersigns the certification; and
- **(B)** the transfer is an **appropriate** transfer…. [next slide]
- A certification described in clause (ii) or (iii) of subparagraph (A) shall include a **summary of the risks and benefits** upon which the certification is based.

"Appropriate" Transfer (c)(2)

- An appropriate transfer to a medical facility is a transfer—
- **(A)** in which the transferring hospital provides…treatment within its capacity which **minimizes the risks** …
- **(B)** in which the receiving facility—
  - **(i)** has available **space** and qualified **personnel**…, and
  - **(ii)** has **agreed** to accept transfer…and to provide appropriate medical treatment;
- **(C)** in which the transferring hospital sends to the receiving facility all medical **records**… available at the time…, including …the informed written consent or certification…provided under paragraph (1)(A), and the name….of any **on-call physician**…who has **refused or failed** to appear within a reasonable time…;
- **(D)** in which the transfer is effected through qualified **personnel** and transportation **equipment**… and
- **(E)** which meets such other requirements as the Secretary may find necessary…

Appropriate Transfers, condensed

- (1) Transferring hospital has **minimized the risks** of transfer by treating the patient within its capacity
- (2) Receiving facility has the available **resources for treatment** and has **agreed to accept** the patient
- (3) Transferring hospital has sent the receiving hospital the necessary medical **records** and other related documents
- (4) Transfer is accomplished by **qualified personnel**
- (5) Procedure meets all other standards in the interest of the health and safety of the patient
  - § 1395dd(c)(2)(A)-(E)

Proper Transportation Equipment

- "[A]ll **physical objects** reasonably medically necessary for safe patient transfer."
  - *Burditt*, 934 F.2d at 1373
- Type of transportation required depends on **circumstances**
  - *Smith v. Janes*, 895 F. Supp. 875 (S.D. Miss. 1995) (fact issue re whether hospital should have used **air or surface ambulance**); *Wey v. Evangelical Comm. Hosp*., 833 F. Supp. 453, 466 (M.D. Pa. 1993) (transport in **car instead of ambulance** was proper under facts of the case)
- Plaintiff will normally have to present **expert testimony** that a reasonable physician would not have used the method of transportation or equipment defendant hospital used
  - *Burditt,* 934 F.2d at 1373.

Transfer Documentation

- Technical violation: Hospital not liable for **clerical deficiency** in record-keeping, where MD complied with Act in all aspects but failed to include **written summary** of specific risks of transfer
  - *Vargas by & Through Gallardo v. Del Puerto Hosp*., 98 F.3d 1202, 1204 (9th Cir. 1996)
- MD could show through **extrinsic evidence** that he weighed the appropriate factors before transfer.
  - *Id*. at 1205; *Accord Kilcup*, 57 F. Supp. 2d at 930 (even if certification is not written, MD may satisfy the requirement by convincing evidence that he made evaluation)
  - *Romo v. Union Mem'l Hosp., Inc*., 878 F. Supp. 837, 844 (W.D.N.C. 1995) (absence of summary does not necessarily result in EMTALA liability but creates jury question)

Transfer Documentation, 2

- Transfer of **stable** pt before securing hospital's express **consent** not actionable. Requirement that transferring hospital obtain consent of receiving hospital applies to transfers of **unstabilized** patients only
  - *See Cherukuri v. Shalala*, 175 F.3d 446, 448 (6th Cir. 1999)
- Where receiving hospital had sufficient medical records from some source to provide required treatment, transferring hospital's failure to provide chart not actionable
  - *Kenyon v. Hosp. San Antonio, Inc*., 951 F. Supp. 2d 255, 2013 U.S. Dist. LEXIS 91605, 2013 WL 3243557 (D.P.R. 2013).

Required of the Certification, §489.24 (e)(1)

- Express written physician certification
  - Cannot simply infer from chart findings and fact of transfer
- Reason(s) for transfer
  - **Need not repeat** facts already in the chart
  - Give **complete picture** of benefits expected from care at the receiving facility and the risks associated with transfer
    - Including time away from an acute care setting
  - Make certification **specific to pt's condition** at transfer
    - May include rationale on certification form or in chart
- May not backdate certifications
  - Interpretive Guidelines: §489.24(e)

Evaluation Required

- Doctor violated EMTALA by signing transfer authorization certifying that risks of transfer were outweighed by benefits without actually weighing risks and benefits
  - *Burditt v. U.S. HHS,* 934 F.2d 1362 (5th Cir. 1991)
- But certification need not necessarily be separate document
  - *Kenyon v. Hosp. San Antonio, Inc*., 951 F. Supp. 2d 255, (D.P.R. 2013)(attending's note that minor patient needed to be transferred to academic center for a pediatric nephrologist and dialysis is certification that patient needed to be transferred

Evaluation Sufficient; Transfer Proper

- Defendant hospital provided for transfer in best interests of patient, (c)(1)(A)(ii), because, as noted in doctor's certification, plaintiffs' son needed gastroenterologist, none was present at hospital, and, therefore, pt needed to be transferred because **benefits of advice from gastroenterologist outweighed dangers of transport**
  - *Ramos-Cruz v. Centro Medico Del Turabo*, 642 F.3d 17 (1st Cir. 2011)

Evaluation Insufficient

- After jury found that hospital was liable for transfer of expectant mother needing emergency delivery, hospital was not entitled to judgment notwithstanding verdict or new trial based on doctor's transfer certification because certification was invalid. Doctor:
  - Gave **improper consideration** to significant factors
  - **Did not deliberate** and weigh risks and benefits of transfer
  - **Did not make reasonable determination**, based on available information, that medical benefits reasonably expected from transfer outweighed foreseeable risks to expectant mother and her unborn child
    - *Heimlicher v. Steele,* 615 F. Supp.2d 884 (N.D. Iowa 2009)

Level of Confidence

- "Ps…assert..that Dr. Niebla was not sure that Molina's EMC, her respiratory distress, was not going to deteriorate on her way…[P]laintiff's contention…is incorrect. A hospital needs only to assure, **within reasonable medical probability**, that no material deterioration of an EMC is likely to occur during transfer. 42 U.S.C. § 1395dd(e)(3)(A). *See also Fraticelli-Torres v. Hosp. Hermanos*, 300 Fed. Appx. 1, 4-9. (1st Cir. 2008) (A hospital's duty…to provide necessary treatment…to assure, within a reasonable degree of medical probability, that his [EMC] is not likely to deteriorate materially…is fulfilled if the patient was stable at…transfer). [P] testified that Molina was stabilized at DCH, and that her breathing was better during her transfer…Molina was not only stable at…transfer, she was stable during [it] as well….Ps have failed to show that Dr. Niebla and DCH did not assure, within reasonable medical probability, that Molina's respiratory distress would not materially deteriorate during her transfer..."

  - *Vega-Feliciano v. Doctors' Ctr. Hosp., Inc*., 2015 U.S. Dist. LEXIS 55845 (DPR 2015)

Patient Preference

- ERP's certification of risks and benefits of transfer of unstable patient adequate under (c)(1), even if patient was too ill to give informed consent, where patient's **daughter requested transfer**, and **patient insisted** on it
  - *Kilcup v. Adventist Health, Inc*., 57 F.Supp.2d 925 (N.D. Cal.1999), *affd* 232 F.3d 894 (9th Cir. 2000)
- That MVA patient with leg fx and other injuries voluntarily signed **waiver** before leaving to go to another hospital, after waiting for hours to receive treatment, did not preclude finding that patient was **transferred before she was stabilized** in violation of…(d)(2).
  - *Sastre v. Hospital Doctor's Ctr., Inc*., 93 F.Supp.2d 105 (D. Puerto Rico 2000)

Consent of Transferee Hospital

- To state claim for violation of (c)(2)(b), P must establish:
  - (1) patient had EMC
  - (2) hospital actually knew it, and
  - (3) patient was transferred before being stabilized
  - 4th prong--that before transfer transferring hospital did not obtain proper consent or follow certification and transfer procedures--N/A where "transfer" is solely **discharge** of patient from initial hospital
    - *Mazurkiewicz,* 223 F. Supp. 2d 661 (E.D. Pa. 2002)
- Receiving hospital **may not refuse** to accept transfer on grounds that it does not approve the **method of transfer** arranged by the attending physician at the sending hospital
  - Survey and Certification Letter S&C–07–20 (April 27, 2007)

Specialized Facilities

- Hospital with, e.g., a burn unit or NICU must accept transfers requiring such services, even if it has no ED
  - §1867(g) of the Act; 42 CFR 489.24; 73 (161) FR. 48655 (8/19/08)
- Transport: Such a hospital with the necessary capacity may not condition or attempt to condition acceptance on use of a particular **mode of transport** or transport service. **Treating MD** at transferring hospital **decides** on transport, since he has assessed pt personally. Transferring hospital must arrange transport that **minimizes risk**
  - §489.24(e)(2)(B)(iv)
- Hospitals that deliberately **delay moving pt** from EMS stretcher do not thereby delay time when EMTALA obligation begins. "Parking" EMS pts, refusing to release EMS personnel or equipment, can jeopardize the health and safety of pt and others in the community who may need EMS services at that time
  - Interpretive Guidelines: §489.24(f)

Transfers to Specialty Hospitals

- Hospital does not necessarily violate EMTALA and/or hospital CoPs if it does not, in every instance, **immediately assume** from EMS all responsibility for the individual, regardless of any other hospital circumstances
  - Interpretive Guidelines: §489.24(f)
- If individual presents to hospital with DED, gets an appropriate MSE, is found to have an EMC, and is admitted for stabilizing treatment, admitting hospital has met its EMTALA obligation, even if she remains unstable. Hospital with **specialized capabilities has no obligation** under EMTALA **to accept a transfer** of that individual from the referring hospital
  - § 489.24(f) N/A individual admitted under § 489.24 (d)(2)(i)
    - Interpretive Guidelines: §489.24(f); 73 (161) FR 48659 (8/19/08)
    - **N/A observation status**
      - §489.24(f)(2)

No EMTALA Duty to Transfer

- Serious but unspecified leg injury 2°MVA; pt died before ordered transfer could be carried out
  - *Maldonado-Rodriguez v. St. Luke's Mem. Hosp., Inc*., 940 F. Supp. 2d 30, 2013 (D.P.R. 2013), citing *Fraticelli-Torres v. Hosp. Hermanos*, 300 Fed.Appx. 1, 7 (1st Cir.2008) (unpublished)

No EMTALA Duty to Transfer Timely

- Failure of hospital to rapidly transfer patient whose[elective cervical spine neurosurgical procedure was complicated by esophageal laceration fails to state EMTALA claim
  - *Baney v. Fick*, 2015 U.S. Dist. LEXIS 21118, 2015 WL 758309 (M.D. Pa. 2015)
- Transfers from a hospital's inpatient wards are not governed by EMTALA but rather by Medicare's Conditions of Participation (and state med mal law)
  - *Matta-Rodríguez v. Ashford Presbysterian Cmty. Hosp.*, 60 F. Supp. 3d 300, 2014 U.S. Dist. LEXIS 98251, 2014 WL 3592087 (D.P.R. 2014)

Violating the Certification Provision

- [1] Before transfer, hospital fails to secure the required **signature** from the appropriate medical personnel…
- [2] Signer has not actually **deliberated** and weighed the risks and benefits of transfer before executing…
- [3] Signer makes an **improper consideration** a significant factor in the certification decision
- [4] Signer actually concludes in the weighing process that transfer's **risks outweigh benefits**, yet signs a certification that the opposite is true
  - *Burditt v. U.S. Dept. of Health and Human Serv.*, 934 F.2d 1362, 1371 (5th Cir. 1991)

No Transfer, No Claim

- Where decedent went to hospital's ER and died at hospital next a.m., family members' claims for failure to stabilize failed because decedent was never transferred:
  - (1) Physician's **order** that decedent was to be transferred ASAP **did not effectuate** "transfer" for EMTALA purposes, and
  - (2) Decedent **never left** hospital's facilities
    - *Alvarez-Torres v Ryder Mem. Hosp., Inc*., 582 F3d 47 (1st Cir. 2009)
- Transfer includes discharge of individual outside hospital's facilities at direction of any person employed by hospital
  - *Morgan v. N. Miss. Med. Ctr., Inc.,* 403 F. Supp. 2d 1115 (S.D. Ala.2005)

No Transfer: No Claim, 2

- "[O]nce an EMC is detected, § 1395dd(b) requires hospitals to stabilize…*or* transfer the patient to another facility…The facts alleged in the [complaint] suggest that Defendants elected to admit Plaintiff to their ER to provide further examination,…and then elected to admit him to the hospital instead of transferring him…And, as with his stabilization claim for this visit, any EMTALA requirement to transfer Plaintiff **ended when he was admitted** to WMH. *See Bryant*, 289 F.3d at 1168."
  - *Leimbach v. Haw. Pac. Health*, 2015 U.S. Dist. LEXIS 95397 (D. Haw. 2015)

Not a Transfer

- Individual initially screened in a department or facility on-campus outside ED: can move to another department or facility on-campus for further screening or stabilizing without transfer, if
  - (1) all persons with the **same** medical **condition are moved** in such circumstances, regardless of ability to pay for treatment
  - (2) there is ***bona fide*** **medical reason** to move the individual; and
  - (3) **appropriate medical personnel** accompany him
- Same holds true for an individual who presents to DED who must be moved to another hospital-owned facility or department on-campus for further screening or stabilizing treatment
  - E.g., eye injury patient needing stationary ophthalmology equipment in eye clinic
    - Interpretive Guidelines §489.24(a)(1)(i)

Transfer of Laboring Mothers

- Hospital cannot cite State law or practice as basis for transfer
- **Transfer agreements**: Must still meet EMTALA screening, treatment, and transfer requirements
- **Transferring hospital**: document its communication with receiving hospital
  - Date and time of transfer request
  - Name and title of person accepting transfer
- Send test results or records not available at transfer ASAP after transfer
  - Tests: phone, then send electronically
  - Transfer is in pt's best interests: don't delay for records or tests
- EMTs may not always be QMPs for transfer purposes
  - Interpretive Guidelines: §489.24(e)

Liability for Transfer

- Hospital's discharge of indigent, pregnant woman with instructions to go to facility approximately 200 miles and 4 hours' driving time away to deliver her baby was violation
  - *Owens v. Nacogdoches County Hosp. Dist*., 741 F.Supp. 1269 (E.D. Tex. 1990)

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Thank You for Attending!

Questions? Comments?

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