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EMTALA Update 2001

Guidelines, developments, and recent court opinions

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Editor's Note:

For physicians, there are no more ominous and confusing federal regulations than those imposed by the Emergency Medical Treatment and Active Labor Act (EMTALA). Because hospitals rely on emergency physicians to understand and ensure implementation of EMTALA regulations, the goal of this issue of ED Legal Letter *is to facilitate a better understanding of the federal requirements to improve compliance and thereby prevent avoidable costly penalties to hospitals and physicians.*

It is important to recognize the recent name change in the governing body that regulates EMTALA to avoid confusion. On June 14, 2001, the Secretary of the Department of Health and Human Services (HHS) changed the name of the Health Care Financing Administration (HCFA), to the Centers for Medicare and Medicaid Services (CMS). The regional offices of CMS are responsible for investigating complaints of alleged EMTALA violations and forwarding confirmed violations to the HHS' Office of the Inspector General (OIG)

Note to readers:

With this issue, **James R. Hubler**, MD, JD, begins serving as executive editor of *ED Legal Letter.* A member of the editorial board since August, Dr. Hubler is an attending physician and a clinical instructor of surgery, Department of Emergency Medicine, University of Illinois College of Medicine at Peoria, OSF St. Francis Hospital, Peoria. He also serves as EMS medical director, Central Illinois Center for Emergency Medicine (CICEM), OSF St. Francis Hospital, Peoria. Dr. Hubler received a dual MD/JD from Southern Illinois University Schools of Law and Medicine. We welcome Dr. Hubler, and look forward to his contributions and guidance. We also would like to thank Robert Bitterman, MD, JD, FACEP, for his service as interim executive editor.

for possible imposition of civil monetary penalties. Readers may encounter references in this and previous articles that refer to HCFA or CMS; they are referring to the same agency, CMS.

Of great concern to numerous hospital officials and physicians is the uncertainty about the extent of their responsibilities under EMTALA. More than 40% of emergency physicians and more than 60% of emergency department (ED) directors responding to a recent OIG survey reported that some parts of the EMTALA law or regulations were unclear.[1] Providers have raised questions about the amount of care they are required to give patients to comply with certain EMTALA requirements and about when their obligations under EMTALA end. CMS officials acknowledge that hospitals and physicians have had difficulty implementing some EMTALA regulations and guidelines and that additional guidance is needed. CMS has identified several areas in which it believes its position needs to be further explained and clarified, including:

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the definition of a hospital's campus, the application of EMTALA in areas that have state or local emergency medical system policies, and the responsibilities of hospitals to provide on-call coverage in EDs. The OIG recently recommended that CMS re-establish an EMTALA technical advisory group (in the past the agency had such an advisory group) to help the agency resolve emerging issues related to the law. CMS officials reported that they are planning to establish such a group to help clarify issues.[2] In July 2001, CMS issued an advisory bulletin in question-and-answer format that helps clarify some areas of concern. ***(To see a selection of CMS questions, please see insert.)***

The December 2000 issue of ED Legal Letter *used case examples to illustrate what happens when a patient "comes to" the ED. It included defining "off-campus" facility requirements in regard to the medical screening exam and what, if any, stabilizing treatment was required. This update addresses a recent report on EMTALA implementation and enforcement by the U.S. General Accounting Office (GAO), pertinent parts of the CMS question and answer guide released in July 2001, and recent EMTALA cases that have been decided in the last year regarding telemetry radio calls and psychiatric patients are summarized.*

Brief Review of EMTALA

In 1986 Congress enacted EMTALA as part of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).[3] It was passed in response to a growing concern that hospitals were "dumping" patients — inappropriately transferring uninsured patients in unstable conditions.[4] The law was enacted to protect indigent or uninsured ED patients against indifferent or disparate medical practices in our nation's EDs.[5]

EMTALA applies to emergency care rendered to all patients presenting to hospitals that have a Medicare contract and receive third-party payment from Medicare or Medicaid for medical services.[6] Approximately 98% of hospitals in the United States participate. There is no requirement for a hospital to have an organized ED for EMTALA to apply. The obligation to treat emergencies is applied to all Medicare contract holders if a person presents for care, even if they only have capability to provide first aid or minimal care and assistance. Recently, EMTALA guidelines have extended the regulations to include a patient who "comes to" a hospital-owned facility that is non-contiguous or off-campus

(i.e., hospital clinics and urgent/prompt cares) if they operate under the hospital's Medicare provider number.[7] EMTALA regulations also may apply to admitted hospital patients.[8]

EMTALA requires that any individual presenting to an ED requesting an examination, or on whose behalf an examination is being requested, be provided with an "appropriate medical screening examination" within the capability of the hospital. The purpose of the medical screening exam is to detect whether an emergency medical condition exists.[9] The examination includes the use of ancillary services routinely available to the ED.[10]

If no emergency medical condition is found during the screening exam, the requirements of EMTALA are met and the duty to the patient under EMTALA ends. CMS uses terms "stable for transfer" (a physician believes a patient's condition will not materially worsen during transfer to another facility) and "stable for discharge" (a patient can reasonably be cared for as an outpatient or later as an inpatient).[11] When the determination is made that a patient is stable for transfer or discharge, the hospital's EMTALA obligation ends. The regulations on transfer requirements refer to patients who are unstable; therefore, they do not apply when a patient is stable for transfer or stable for discharge. The obvious danger here has been the stable patient who suddenly becomes unstable during transfer. Also, "stabilized" may be defined differently by CMS and emergency physicians. Stabilized patients must be given plans for appropriate follow-up care. Although there is no hospital obligation under EMTALA to provide follow-up outpatient care, many hospital bylaws require on-call physicians to provide one (or more) follow-up visits after a patient is seen in the ED.

If an emergency medical condition is discovered, or if the patient is in labor, EMTALA requires stabilizing treatment.[12] EMTALA restricts the transfer of patients with emergency medical conditions or women in labor until the condition has been stabilized, unless the medical benefits of transferring the individual to another facility outweigh the risks to the individual (and to the unborn child if the patient is in labor).[13] A receiving hospital may not refuse an appropriate transfer.[14]

Hospitals that receive inappropriate patient transfers are required to report suspected EMTALA violations within 72 hours; it is important to recognize this is a *hospital* obligation, not a *physician* obligation.[15] A review and internal analysis performed in collaboration with hospital staff and counsel is advised before reporting a violation. (While not required, hospitals should have an identifiable EMTALA committee available to investigate potential claims.)

While both hospitals and physicians can be fined for violations, patients may sue only *hospitals* under EMTALA. Patients cannot sue physicians directly for alleged EMTALA violations. In addition, the statute does not create a private malpractice cause of action against physicians for injured patients. The injured patient may pursue legal remedy against a physician who did not meet the standard of care by filing suit for professional negligence. Such a claim normally would be covered by the physician's professional liability coverage. Insurers generally do not cover physicians' monetary EMTALA penalties that are administered by the OIG. This creates a potentially large out-of-pocket expense for sanctioned physicians.

The statutory language of EMTALA is subject to interpretation by the courts. This year's appellate court cases have examined the law's application to psychiatric patients, and to patients in private ambulances who have not yet arrived to the ED. Discussion of these cases will provide emergency physicians with a better understanding of EMTALA regulations.

The General Accounting Report on EMTALA

Due to medical community concerns that implementation and enforcement of EMTALA has created burdens on hospitals and physicians, the U.S. GAO published a report on June 22, 2001.[16] This 34-page report (referred to here as the GAO report) outlines in exacting detail the investigation process, which is far too encompassing and detailed to address completely in this issue. CMS is responsible for investigating complaints of alleged EMTALA violations. CMS does not have the authority to impose monetary fines; however, it has the authority to terminate the Medicare provider agreement of a hospital that has violated EMTALA. CMS forwards confirmed violations to the OIG for possible imposition of civil monetary fines. OIG then investigates and determines if the violation warrants further investigation and penalties.

The number of EMTALA violations and fines has been relatively small, and hospital Medicare provider agreements rarely have been terminated. Since 1995, CMS regional offices have directed state survey agencies to investigate about 400 hospitals per year, and cited about half of them for EMTALA violations. In fiscal year 1999, CMS conducted 431 investigations and found 215 confirmed violations.[17] If CMS

determines that a violation has occurred, it immediately initiates the process to terminate the hospital's Medicare provider agreement, the only action its statutory authority permits. However, most cited hospitals develop corrective action plans to resolve deficiencies, thereby avoiding termination. Since EMTALA was enacted, only four hospitals have had their provider agreements terminated for EMTALA violations, and two of those were recertified.[18]

In determining whether enforcement action beyond termination by CMS is appropriate, the OIG has more discretion and flexibility, including civil and monetary penalties and setting of fines. OIG relies on the state survey report, peer review, and information collected by CMS. OIG considers several other factors in making this decision and in determining the amount of a fine, including the seriousness of the patient's condition, the nature of the violation, the culpability of the hospital or physician, and the effect of the penalty on the hospital's ability to provide care.[19] From 1995 through 2000, the OIG imposed fines totaling more than $5.6 million against 194 hospitals and 19 physicians. The majority of hospital fines were $25,000 or less. The total number of physicians who have ever been fined by the OIG for EMTALA violations is 28.[20] The number of confirmed EMTALA violations is relatively small compared to the total number of ED visits in one year (97 million in 1999, for example).[21] The average annual number of hospitals with confirmed violations represents fewer than 5% of hospitals with EDs. From Jan. 1, 1995, through March 30, 2001, the OIG processed a total of 605 EMTALA violation cases; 237 cases were settled and 368 cases were declined. Overall, the OIG has declined about 61% of the violation cases forwarded by CMS.

The OIG has the authority to assess civil monetary penalties against physicians, and it examines the activities of the individual physician involved in every case forwarded by CMS. The OIG pursues a case against a physician only if it considers the physician largely responsible for the violation. Overall, the OIG has sought civil monetary penalties from 28 physicians and collected $412,500; it generally does not pursue a physician unless clearly culpable behavior is involved, such as an on-call physician refusing to come to the hospital when asked by the hospital to treat a patient.

Interestingly, the GAO report referenced the 1999 Special Advisory Bulletin, which stated a hospital could violate EMTALA if it routinely keeps patients waiting so long that they leave without being seen, particularly if the hospital fails to determine and document why individual patients are leaving and advise them that the hospital is prepared to provide a medical screening exam if they stay.[22] (See ***ED Legal Letter***, December 2000, *Vianey Malave Sastre v. Hospital Doctor's Center Inc*.,[23] in which a patient waited several hours for treatment and finally left, and signing out against medical advice. Despite her refusal, the hospital was fined for not providing an appropriate medical screening exam.)

To evaluate the cause-and-effect relationship of whether increased ED use can be attributed to EMTALA, the GAO report looked at the U.S. population increase and the number of people who are uninsured. They found that many EDs have experienced an overall increase in patient volume. From 1994 to 1998, the U.S. population increased by about 4%. During the same period, ED visits nationwide increased from about 90.5 million annually to 94.8 million, an increase of about 5%. While some states had a dramatic increase (12% increase in California), others suffered a decline (Georgia experienced a 10% decline).[24] Between 1994 and 1998, the number of uninsured Americans grew steadily from 39.4 million (17.1% of the nation's non-elderly population) to 43.9 million (18.4% of the non-elderly population). Uninsured people are less likely to have a regular source of health care and are more likely to have difficulty gaining access to care. Compared with the insured, uninsured adults and uninsured children are, respectively, four and five times more likely to use the ED.

Hospitals and physicians reported that EMTALA has helped to ensure access to emergency services by reducing the incidence of patient dumping. In addition, they reported EMTALA has made it easier for hospitals to ensure that physicians who participate in on-call panels come to the hospital when asked. Another positive outcome is that EMTALA has enabled managed care beneficiaries to receive care without waiting for hospitals to gain prior authorization. Representatives of tertiary care hospitals and public hospitals, which are more likely to receive patient transfers from other hospitals, agree that EMTALA has reduced the number of inappropriate transfers they receive, but report that transfers based on financial factors continue to occur.[25] There were reports of transferring hospitals claiming that patients needed specialized care when, in fact, the transferring hospitals could adequately care for the patients within their capabilities. Furthermore, representatives of public hospitals reported that some hospitals operating within larger hospital networks were transferring uninsured patients

to public hospitals instead of to hospitals in their networks that were capable of providing care.

The GAO report stated that confirmed violations are an imprecise measure of patient dumping because suspected violations may not always be reported. For example, hospital officials noted that they may not always report possible cases of patient dumping because they are reluctant to jeopardize their relationships with other hospitals in their community. These hospitals noted that they need to maintain a positive working relationship with other hospitals and sometimes they rely on other facilities for patient referrals.

The GAO report addressed issues related to on-call physicians. Hospital and physician representatives reported that uncompensated care associated with complying with EMTALA has contributed to a decline in the number of physicians willing to serve on ED on-call panels. In addition, some physicians limit their time on call or completely avoid participating in the on-call panel. Furthermore, they said that some specialists are reducing the number of procedures that they have credentials to perform and are not seeking privileges at hospitals in efforts to avoid being on call, which is resulting in a reduced range of services.[26] The report other factors other than EMTALA that also may affect physicians' willingness to serve on call. In the past, physicians in certain specialties had inducements to join hospital staffs and provide on-call services because they were dependent on the hospital setting to be able to perform procedures and needed emergency patients to build their practices. Today, however, they can perform many procedures in outpatient settings and gain patients through managed care networks, resulting in fewer advantages to balance the inconveniences of serving on call. Fortunately for hospitals, the report used this example: If a hospital ED was aware that it had a problem with on-call coverage and did not attempt to resolve the coverage shortage, OIG would consider the hospital culpable. If, however, an on-call physician refused to come in despite being told by the hospital of his obligation, OIG would consider the hospital's culpability far smaller.[27]

Hospitals must keep a list of specialty physicians on call to stabilize emergency patients. Some hospitals and physicians believe CMS requires full-time coverage of a specialty if the hospital staff includes three or more physicians in that specialty. Although this sounds like a reasonable call schedule, there is no rule linking extent of coverage to the number of specialists on staff. Physicians are not required to be on call at all times. Further guidance is being developed on what is a reasonable call schedule for physicians.[28]

While the GAO report details the investigative process and reviews the application and pertinent problems of EMTALA, it does not provide administrative guidance of EMTALA. The report is given support (although not definitive authority) because it was reviewed by CMS and thought to be accurate both in its reflection of EMTALA problems and interpretation of enforcement processes, and in its applicability to areas of concern. The report is useful in defining the problems of EMTALA; however, it gives guidance and clarification on only a few issues. The CMS agency has promised further interpretive guidelines, but the release of a complete set of guidelines is still pending.

Cases in 2001

Arrington - Does EMTALA Include Ambulance Contact Through Telemetry? One of the most recognized and controversial cases, *Arrington v. Wong,*[29] from the U.S. Court of Appeals, Ninth Circuit, was decided and overturned on Jan. 22, 2001. On May 5, 1996, at approximately 11:30 p.m., 59-year-old Harold Arrington was driving to his job as a security guard when he experienced difficulty breathing. One of his co-workers called for an ambulance, which arrived shortly after midnight. The ambulance left the scene at 12:24 a.m. to take Arrington to the closest medical facility, Queen's Medical Center, in Honolulu.

Dr. Wong was the ED physician on duty at Queen's. While under way, the ambulance personnel contacted the hospital ED by radio. They relayed the details of Mr. Arrington's medical condition to Dr. Wong. They stated that Mr. Arrington was in severe respiratory distress, speaking 1-2 words at a time, and breathing about 50 times a minute. Dr. Wong asked the ambulance personnel the name of the patient's doctor. The ambulance personnel replied "patient is a Tripler [Army Medical Center] patient, being that he was in severe respiratory distress we thought we'd come to a close facility." Dr. Wong responded: "I think it would be okay to go to Tripler." *(Editor's note: Tripler hospital was four miles farther away.)* The ambulance personnel took this as a directive and changed their route to proceed to the more distant hospital. By the time the ambulance arrived at Tripler, at 12:40 a.m., Mr. Arrington's condition had deteriorated and he suffered cardiac arrest at 12:42 a.m. He was pronounced dead at 1:17 a.m.[30]

In this case, the defendant hospital (Queen's) argued

that "comes to the emergency department" plainly and unambiguously means "arrives at a hospital." The plaintiffs (Mr. Arrington's survivors), however, argued that the phrase included the act of traveling to the hospital. The court looked to *Webster's Third New International Dictionary* and found that it supports both definitions. It defines "come[s] to" as, among other things, to "move toward or away from something . . . *approach* (emphasis added)," or "to arrive at a particular place."[31] The court surmised that purely as a matter of dictionary definition, "comes to the ED" could mean either physical arrival at the ED, or the act of traveling from the scene of an emergency to or toward the hospital.

The court looked for guidance from HHS, which it felt has taken an expansive approach to the scope of the phrase "comes to the emergency department." HHS interprets that statutory phrase broadly, to include not just the ED itself, but all hospital property — sidewalks, outlying facilities, and ambulances — so that once a patient seeking medical treatment presents at any facility or vehicle owned or operated by the hospital, he has "come to" the ED. The court acknowledged that it had previously been recognized that under this provision of EMTALA, individuals in non-hospital-owned ambulances have unquestionably "come to the hospital" when that ambulance is itself on hospital property.

The court relied on the theory provided by HHS clearly recognizing that hospitals could abuse the Act simply by diverting all persons in emergency straits before they arrive on hospital property. Under 42 C.F.R. § 489.24, a hospital cannot avoid its obligation to treat emergency patients simply by preventing individuals in dire straits from reaching the emergency room. To engage in such diversions, the hospital must show that it is in "diversionary status" — that is, that it lacks the staff or facilities to treat a patient. The court here felt that this followed HHS's consistent position that "it would defeat the purpose of EMTALA if we were to allow hospitals to rely on narrow, legalistic definitions of 'comes to the emergency department' to escape their EMTALA obligations."[32] Accordingly, HHS warned that, under § 1395dd, "a facility may not prevent an individual from gaining access to the facility in order to circumvent the requirements [of EMTALA]."[33]

The court here stated that in this case, Mr. Arrington was in a non-hospital-owned ambulance that was en route to Queen's, and the ambulance personnel contacted the hospital's ED on his behalf and requested treatment. By the plain language of the agency's rules, the hospital was obliged to treat Mr. Arrington unless the hospital was in "diversionary status," or in other words, lacked "the staff or facilities to accept any additional emergency patients at the time it was contacted."[34] Queen's did not contend that it was in "diversionary status" at the time Dr. Wong directed Mr. Arrington away from Queen's to the more distant Tripler facility. To be in compliance with EMTALA regulations, Queen's would have had to show that there were insufficient emergency staff available to treat Mr. Arrington at the time the ambulance personnel called the ED; that appropriate staff would not be available by the time Arrington arrived at the hospital; that the hospital did not have the proper equipment with which to treat Mr. Arrington's medical condition; or that the appropriate equipment was unavailable (in use, out of order, etc.). Finally, Queen's would have to have demonstrated that Dr. Wong knew that there were inadequate staff or facilities available, and that he based his decision to redirect Arrington to Tripler on a treatment-related reason, rather than on some other, unrelated factor.

The court reasoned that the decision was not inconsistent with *Johnson v. University of Chicago Hosps.*,[35] in which a group of hospitals shared a telemetry system that directed patients to the appropriate emergency facility. When the paramedics called for permission to bring a pediatric arrest patient to the nearest facility, they contacted the central shared system, which informed them that the nearest hospital had declared a "partial bypass," and directed them to a different hospital within the system. In *Johnson*, the Seventh Circuit explicitly held that "a hospital-operated telemetry system is distinct from that hospital's emergency room," and is not governed by § 1395dd.[36] The court found a distinction in that the ambulance carrying Mr. Arrington directly contacted the Queen's ED; moreover, as noted earlier, there is no contention here that the hospital was on diversionary status. The court held that a hospital may divert an ambulance en route to the ED only if it is in diversionary status.

Discussion. This case was decided by a 2-to-1 vote despite a vigorous dissent which argued, "Congress could have used many different locutions and drawn many different lines when it enacted EMTALA. It could have, for example, said that a hospital could be liable when a request for services was made and somebody was willing and able to bring the person in distress to the hospital. It could have declared that if the person making the request was operating an ambulance heading toward the hospital, the hospital must accept the patient. Congress did not do so. Rather, it said that in

addition to a request for services, the person must come to the hospital's emergency department. The plain meaning of that requirement is that a person must be at the hospital physically. It will not do for him to be in contact through electronic connection, or for him or someone else to hold a hope that he can get there. It surely does not mean 'move toward'; it clearly means to arrive at the place in question."[37] Unfortunately, these arguments were rejected by the two majority judges.

Interestingly, the dissenting judge offered a wonderful example — ". . . if we say come to court at 9 a.m., we mean 'be here,' we do not mean 'be in route.' "[38] Nevertheless, this ruling has implications for all emergency physicians (whose actions may expose their employer hospital to EMTALA penalties) who answer telemetry calls. EMTALA previously had a limited application to patients in hospital-owned or -operated ambulances or ambulances on hospital property. This interpretation of EMTALA regulations extends to patients in private ambulances that aren't owned or operated by hospitals once radio contact is initiated, unless that hospital is on diversion. Currently the "comes to" provision is satisfied when contact is made unless the ED does not have the staff, facilities, or equipment to treat the patient. While the opinion on Mr. Arrington is binding in the 9th Circuit, which includes Alaska, Arizona, California, Hawaii, Idaho, Montana, Nevada, Oregon, Washington, and Guam, the ruling has legal consequences as well for emergency physicians who do not practice in these states. The obvious danger is that other courts may look to this case as persuasive (not binding in other jurisdictions as law) on the issue.

Psychiatric Patients and EMTALA

Jackson v. East Bay Hospital. Decided in April, 2001, *Jackson v. East Bay Hospital*[39] addressed Robert Jackson's visits to Redbud Community Hospital ED in Clearlake, CA.. On April 2, 1996, Mr. Jackson visited the Lake County Mental Health Department to see a psychiatrist. Mr. Jackson previously had been diagnosed with psychotic disorder, borderline intellectual functioning, and pedophilia. The Lake County staff instructed Jackson to go to the Redbud ED to receive a medical clearance before returning to Lake County. At Redbud, a nurse took Mr. Jackson's medical history, vital signs, current medications, and drug allergies. A half-hour later, Dr. Wolfgang Schug, a Redbud ED doctor, examined Jackson and noted that he was reporting hallucination, dizziness, and unsteadiness, and that he was taking Anafranil and Ativan. Dr. Schug diagnosed Jackson as suffering from acute psychosis; neither he nor any other Redbud physician or employee diagnosed Mr. Jackson as suffering from an emergency *medical* (as opposed to a psychological or psychiatric) condition.

Redbud, a 40-bed, rural hospital, did not offer psychiatric care to its patients, and the unwritten policy of the Redbud ED was that when a patient presented to the emergency room with psychiatric complaints, the patient would be examined to determine if there were any medical components to his problem. If a medical problem was found, it took precedence over the psychiatric complaints. If no medical problem was found, the patient would be referred to a psychiatrist or to a mental health facility for an appropriate psychiatric follow-up. Dr. Schug arranged for Lake County (which provided psychiatric care) to see Mr. Jackson upon his release, where he was evaluated by Dennis Skinner, a Lake County employee.

On April 4, Mr. Jackson returned to the Redbud ED. A triage nurse took Mr. Jackson's medical history, vital signs, and current medications. An hour later, Dr. Miguel Ollada, a Redbud emergency room doctor, took a separate medical history and evaluated Jackson, who complained of a sore throat, chest pain while breathing, and dry heaves. Dr. Ollada also observed Mr. Jackson talking to himself. Dr. Ollada performed a complete physical exam, and ordered a battery of tests, including an electrocardiogram, urine drug screen, and blood gas test. The urine analysis indicated the presence of a tricyclic antidepressant, such as the Anafranil Mr. Jackson was known to be taking. Dr. Ollada diagnosed Mr. Jackson as having chest contusions, hypertension, and psychosis, but not drug toxicity.[40] Dr. Ollada gave Mr. Jackson medications, and ordered a mental health consultation, to be conducted at Lake County. Lake County refused to evaluate Mr. Jackson, however, because he recently had been seen by its staff and found to be non-suicidal. Believing Mr. Jackson to be non-suicidal, and his condition to have stabilized, Dr. Ollada released him from Redbud, and he instructed him to return to Lake County the next morning.

At 3:45 a.m. on April 5, Mr. Jackson returned to the Redbud ED after his wife found him wandering in the road in the middle of the night. A nurse performed an initial medical evaluation, and Dr. Ollada performed another examination at 3:50 a.m. Dr. Ollada observed that Mr. Jackson was very agitated, but he also observed that Mr. Jackson had a regular heartbeat, and

that he presented no other physical symptoms. Barbara Jackson told Dr. Ollada that she believed that her husband was suicidal, because she found him in the middle of the road, waving his hands. Dr. Ollada determined that Mr. Jackson was suffering from a psychological disorder that caused his agitation, but that he was not suffering from any physical disorders. Dr. Ollada prescribed and administered Haldol and Benadryl in an effort to sedate Mr. Jackson and to stabilize his condition. Dr. Ollada ordered that Lake County be contacted regarding his condition.

Later in the morning of April 5, Susan Smith, a Lake County crisis worker, evaluated Mr. Jackson and found that his condition met the criteria for involuntary psychiatric commitment, and she concluded that he suffered from a psychological disorder, anxiety, and a dependent personality. Smith then asked Dr. Ollada to clear Mr. Jackson for a transfer to East Bay Hospital, which functioned almost exclusively as a psychiatric hospital. Dr. Ollada found that Mr. Jackson's condition had stabilized (he was no longer agitated, and was sleeping), that he was not suffering from a life-threatening condition, and that a transfer to East Bay Hospital did not pose a risk to Mr. Jackson's condition. At the time of the transfer, Dr. Ollada believed that Mr. Jackson's condition had been stabilized.

At 9:15 a.m., Redbud transferred Mr. Jackson to East Bay, where he was seen by Dr. Spencer Steele, a psychiatrist who performed a psychiatric, but not a physical, examination of Mr. Jackson. Dr. Steele prescribed more Haldol for Mr. Jackson. Shortly before 2 p.m., the East Bay medical staff concluded that Mr. Jackson was so unable to control his own movements that he posed a danger to himself and others. At 2 p.m., Mr. Jackson went into cardiac arrest. East Bay staff began to perform CPR, and they ordered an ambulance to transfer him to Brookside Hospital. Jackson arrived at Brookside's ED at approximately 2:30 p.m. Mr. Jackson received emergency care at Brookside, but he was pronounced dead at 2:37 p.m. An autopsy determined that Mr. Jackson died from sudden cardiac arrhythmia caused by clomipramine (Anafranil) toxicity. None of the doctors or nurses who saw Mr. Jackson at Redbud diagnosed him as suffering from Anafranil (or other drug) toxicity. [41]

Mr. Jackson's survivors argued that Redbud violated EMTALA's screening requirements by providing medically inadequate screening examinations and by failing to order additional tests on April 5, when, they allege, it was obvious that Mr. Jackson was suffering from a physical disorder, and not a psychological one. The survivors also argued that the examinations performed by Redbud's doctors and nurses "were so wanting" as to be "inappropriate" medical screening examinations.[42] Acknowledging the weight of authority supporting the district court's conclusion that an examination does not have to be "medically adequate" to satisfy EMTALA's requirements, the plaintiff asked the appellate court to overrule those precedents. In addition, plaintiffs argued (without evidentiary support) that there is a material possibility that the doctors acted in bad faith because their diagnoses were "inherently implausible." The court rejected all of these arguments and held that Redbud satisfied its EMTALA screening obligations.

The court held that a hospital satisfies EMTALA's appropriate medical screening requirement if it provides a patient with an examination comparable to the one offered to other patients presenting with similar symptoms, unless the examination is so cursory that it is not designed to identify the acute and severe symptoms that alert the physician of the need for immediate medical attention to prevent serious bodily injury. This standard is consistent with Congress's purpose in enacting EMTALA, which was to limit the ability of hospitals to avoid treating poor or uninsured patients. Mr. Jackson's survivors also argue that Redbud failed to stabilize Jackson's emergency medical condition prior to his transfer to East Bay, in violation of 42 U.S.C. § 1395dd(b)(1). The court rejected this argument, stating a "hospital's duty to stabilize the patient does not arise until the hospital first detects an emergency medical condition."[43]

Discussion. The medical screening exam requirement of EMTALA was satisfied despite the misdiagnosis. The court noted that the Redbud doctors and nurses performed these screenings according to Redbud guidelines, and that Mr. Jackson was triaged by a nurse and examined by a doctor during each of his visits to the Redbud ED. During these visits, the physicians performed several physical examinations and ordered multiple laboratory tests. These examinations were not so substandard or of such low quality as to violate EMTALA.

Baker v. Adventist Health, Inc.

Unfortunately for Redbud Community Hospital, it found itself in the spotlight of the appellate court a second time in 2001, in *Baker v. Adventist Health, Inc.; Redbud Community Hospital District; Wolfgang Schug, MD; Janzen, Johnston & Rockwell Emergency Medical Group of California, Inc.*, [44]

decided Aug. 6, 2001. As previously discussed, Redbud is a rural hospital in Clearlake, CA. It operates an ED, but it does not offer psychiatric treatment and has no psychiatrists, psychologists, or any other mental health professionals on staff. The hospital has a written policy (note in the previous case, in April 1996, there was no such written policy) which directs emergency room personnel to consult with the Lake County Mental Health Department when dealing with patients who present with possible psychiatric emergencies. Patients must be "medically cleared" before Lake County is called to perform a mental health evaluation. The policy provides that the emergency physician's examination must be "sufficient to rule out any organic causes of the aberrant behavior."

On Sept. 25, 1996, Henry Baker was brought to the hospital by friends. The nurse who triaged him recorded his chief complaint as "request mental health evaluation." The nurse checked his vital signs, noted no obvious physical problems, and classified Mr. Baker's triage status as "delayed," meaning that he was in a stable condition, was in no distress, and was entitled to less priority than patients with life-threatening or urgent needs.

About 90 minutes later, Mr. Baker was examined by Dr. Schug, mentioned in the previously-described case. Dr. Schug recorded a patient history that includes the notation, "Last 90 days 'apathetic,' unable to communicate, depressed. Suicide 'constantly' in back of mind."[45] Dr. Schug concluded that Mr. Baker had no physical or medical condition requiring immediate care, and recorded his diagnosis as "(1) Depression (2) Medical clearance for mental health." In accordance with hospital policy, Dr. Schug contacted Lake County to request a mental health evaluation of Baker. In his telephone call to Lake County, Dr. Schug reported that Mr. Baker was not saying that he was suicidal, according to the undisputed facts. Dr. Schug testified in his deposition that he could not tell whether Mr. Baker was a danger to himself, and called Lake County to have them make that determination.

Within a half-hour of Dr. Schug's call, Lake County crisis worker Dennis Skinner (previously mentioned in the earlier case) and a trainee arrived at Redbud. Mr. Skinner examined Mr. Baker and concluded that he did not meet the criteria for an involuntary hold under the applicable state statute because Mr. Baker did not constitute a danger to himself or others. Mr. Baker was discharged from Redbud after he agreed to go to Lake County the following day to complete paperwork to qualify for medical expenses and social services. He also was to receive an assessment by a clinician for possible referral to a psychiatrist for the treatment of depression. Both Dr. Schug and Mr. Baker signed the discharge record, which noted that there was to be a mental health follow-up. Mr. Baker's body was found two days later, after he had hanged himself from a tree.

The essence of the plaintiff's case is that Redbud was required under EMTALA to provide a psychiatric examination with the hospital's own personnel, and that it violated the statute by calling in Lake County to screen Mr. Baker for a psychiatric emergency. The court rejected the argument that Redbud should have provided a mental health screening itself rather than calling in the county mental health department. The court found that "this is not a tenable position under the statute, however, for the statute explicitly limits the screening examination that the hospital is required to provide to one that is 'within the capability of the hospital's ED, including ancillary services routinely available to the emergency department.'"[46] The hospital did not have the capability to perform a mental health screening. Nor are mental health services listed in Redbud's written policy detailing ancillary services available to the ED. Therefore, Redbud did not have any duty to provide Mr. Baker with a mental health screening. For the purposes of our EMTALA analysis, the mental health evaluation performed by Lake County was entirely gratuitous. Redbud discharged its responsibility under EMTALA by performing a medical screening. Accordingly, Redbud did not violate EMTALA by calling in Lake County to conduct a mental health evaluation that was beyond the hospital's capabilities.

The plaintiff argued that psychiatric services were indeed within the capability of Redbud's ED, since Dr. Schug took psychiatry courses during medical school and has been exposed to psychiatric patients as an emergency room physician. The plaintiff did not contend and could not successfully contend that such experience could give Dr. Schug any material expertise in psychiatry beyond that of the ordinary medical doctor with some ED experience. Moreover, "hospitals, and not reviewing courts, are in the best position to assess their own capabilities."[47] A standard screening policy for patients entering the ED generally defines which procedures are within a hospital's capabilities. Here, Redbud's policy required Lake County crisis workers, rather than Redbud staff, to perform mental health screenings. The uncontested evidence establishes that mental health screenings were beyond the capability of Redbud's ED.

The plaintiff also argued that the hospital violated

EMTALA by failing to stabilize an emergency medical condition, by disparately applying its mental health policy to Mr. Baker, by discriminating against persons who have psychiatric as opposed to physical emergency conditions, and by improperly transferring Mr. Baker to Lake County before he was stabilized. The court rejected this argument. The court found that EMTALA explicitly recognizes the differences among the capabilities of hospital EDs, so the statute limits the screening required to one that is within the capability of a given ED.[48] The court held that Redbud cannot be charged with discriminating against psychiatric patients by failing to provide them with psychiatric screenings, where the hospital lacked any mental health capability.

Discussion. This case illustrates that those hospitals without psychiatric facilities may utilize state agencies to aid in the evaluation and treatment of psychiatric patients. The argument that emergency physicians are not qualified to do a mental health screening exam or determine, after evaluation, whether someone is in need of further inpatient or outpatient psychiatric care is inconsistent with the training and education of residency-trained emergency physicians. The case does not answer the question of whether hospitals with psychiatric facilities may use state mental health evaluations instead of in-house psychiatrist evaluation.

Of interest to emergency physicians, the court argued that even if a duty to stabilize had arisen, Dr. Schug's request for an examination by Lake County was not a "transfer" within the meaning of EMTALA. The statute defines "transfer" in relevant part as "the movement (including the discharge) of an individual outside a hospital's facilities at the direction of any person employed by (or affiliated or associated, directly or indirectly, with) the hospital . . ."[49] There was no movement of Baker outside the hospital's facilities, since Mr. Skinner performed the mental health evaluation of Mr. Baker in Redbud's ED. The other looming EMTALA question is whether hospitals with psychiatric facilities can transfer patients following a screening examination in the ED to a state facility for inpatient treatment.

Conclusion

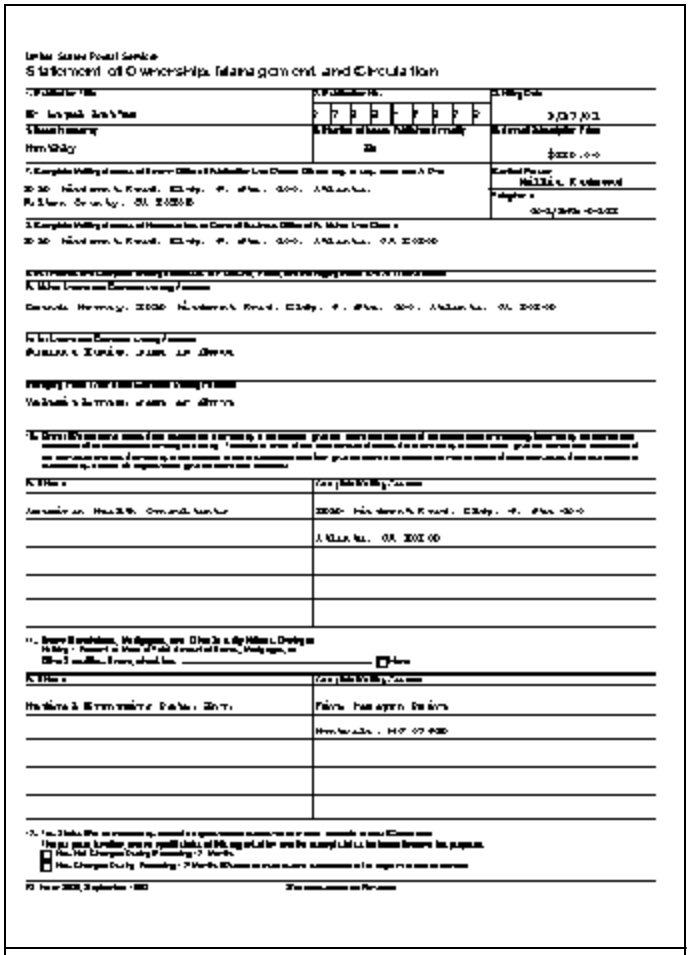
The last year's cases, the GAO report, and CMS's unusual way of publishing guidelines all have aided in the interpretation of EMTALA requirements. The case law supports use of state agencies in evaluation of psychiatric patients to satisfy the screening examination requirement of EMTALA in those hospitals without psychiatric facilities. Whether this is applicable to facilities with psychiatric facilities is yet unanswered. Consistent with numerous previous decisions, a misdiagnosed or unrecognized medical condition that is not discovered during a reasonable medical screening examination is not a violation of EMTALA. The Arrington case has unfortunately expanded the "comes to" provision of EMTALA regulations to patients in non-hospital owned and operated ambulances that contact the hospital through telemetry, unless the hospital is on bypass.

The GAO report outlines the investigative process and the authority of CMS and OIG in evaluating claims of EMTALA violations. The GAO report does recognize the difficulty in interpretation of EMTALA requirements. Further clarification and guidance regarding EMTALA's requirements and application is needed by CMS. The need for an advisory group is illustrated in the CMS question and answer guidelines. Perhaps the long-awaited complete guidelines will be available in our next EMTALA update.

Endnotes

1. The Emergency Medical Treatment and Labor Act: Survey of Hospital Emergency Departments, Department of Health and Human Services, Office of Inspector General, Jan. 2001.
2. Report to Congressional Committees, United States General Accounting Office GAO, June 2001 Emergency Care, EMTALA, Implementation and Enforcement Issues. GAO-01-747. GAO report page 16. [Hereinafter GAO report] To order a copy by phone call (202) 512-6000 or fax: (202) 512-6061. To find copy by Internet visit GAO's World Wide Web home page at: www.gao.gov. (Accessed 10/30/01.
3. 42 U.S.C. § 1395dd.
4. *Brooks v. Maryland Gen. Hosp., Inc.*, 996 F.2d 708, 710 (4th Cir. 1993).
5. *Id*. at 710-711; Baber v. Hospital Corp. of Am., 977 F.2d 872, 880 (4th Cir. 1992); *Gatewood v. Washington Health care Corp*. 933 F.2d 1037, 1039 (D.C. Cir. 1991).
6. 42 U.S.C. § 1395cc.
7. Interpretive Guidelines - responsibilities of Medicare par ticipating hospitals in emergency cases - guide to site surveyors. 42 C.F.R. § 489.10 June 1,1998 [hereinafter Site surveyors guide].
8. *Roberts v. Galen* 119 S. Ct. 685 (1999).
9. The Act defines an "emergency medical condition" as a condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in: 1) placing the health of the individual, pregnant woman or unborn baby in serious jeopardy: 2) serious impairment to bodily functions: or 3) serious dysfunction of any bodily organ or part. 42 U.S.C. § 1395dd(e)(1)(A).
10. 42 U.S.C. § 1395dd(a).

11. 42 U.S.C. § 1395(e)(3)(A).
12. 42 U.S.C. § 1395dd(b).
13. 42 U.S.C. § 1395dd(C). *Johnson v. Univ. of Chicago Hosp.* 982 F.2d 230, 232-33 (7th Cir. 1992); *Green v. Touro Infir mary*, 992 F.2d 537, 539 (5th Cir. 1993).
14. Nondiscrimination – "A participating hospital that has specialized capabilities or facilities (such as burn units, shock-trauma units, neonatal intensive care units, or (with respect to rural areas) regional referral centers . . . shall not refuse to accept an appropriate transfer of an individual who requires such specialized capabilities or facilities if the hospital has the capacity to treat the individual." 42 U.S.C.& 1395dd(g).
15. 42 C.F.R. § 489.20(m) (1995).
16. GAO Report.
17. GAO report at 19.
18. GAO report at 4.
19. GAO report at 24.
20. GAO report at 5.
21. GAO report at 18.
22. GAO report at 6; 742 U.S.C. Sec. 1395cc.; 842 CFR Sec. 489.20 and Sec. 489.24.
23. 93 F.Supp.2d 105 (D.P.R. 2000). See *ED Legal Letter*, "EMTALA Update 2000: Coming to the ED," for further discussion on this issue.
24. GAO report at 9.
25. GAO report at 11.
26. GAO report at 14.
27. GAO report at 24.
28. GAO report at 17.
29. 237 F.3d 1066 June 2001.
30. Facts also taken form district court opinion *Arrington v. Wong*, 19 F. Supp 2d 1151 (D. Hawaii 1998).
31. *Webster's Third New International Dictionary of the English Language Unabridged, (1986)*Philip Babcock, ed. Springfield, MA; Merriam-Webster: 453.
32. Arrington at 1073. The court here referencing 65 Fed.Reg. 18,434, 18,522 (April 7, 2000). 42 C.F.R. § 489.24.
33. The Arrington court here citing EMTALA 59 Fed.Reg. 32,086, 32,098 (June 22, 1994) (codified at 42 C.F.R. § 489.24).
34. *Id*. at 1073.
35. 982 F.2d 230 (7th Cir.1992) (per curiam).
36. *Id*. at 233.
37. 237 F.3d 1066, 1075.
38. *Id*. at 1077 found in footnote #2.
39. 246 F.3d 1248 April 2001.
40. *Id*. at 1253.
41. 1254.
42. *Id*.
43. *Id*. at 1257. The court here citing, Eberhardt, 62 F.3d at 1259.
44. 260 F.3d 987 United States Court of Appeals, Ninth Cir cuit. *Baker v. Adventist Health Inc.; Redbud Community Hos pital District; Wolfgang Schug, M.D.; Janzen, Johnston & Rockwell Emergency Medical Group of California, Inc.*, Aug. 6, 2001.
45. *Id*. at 988.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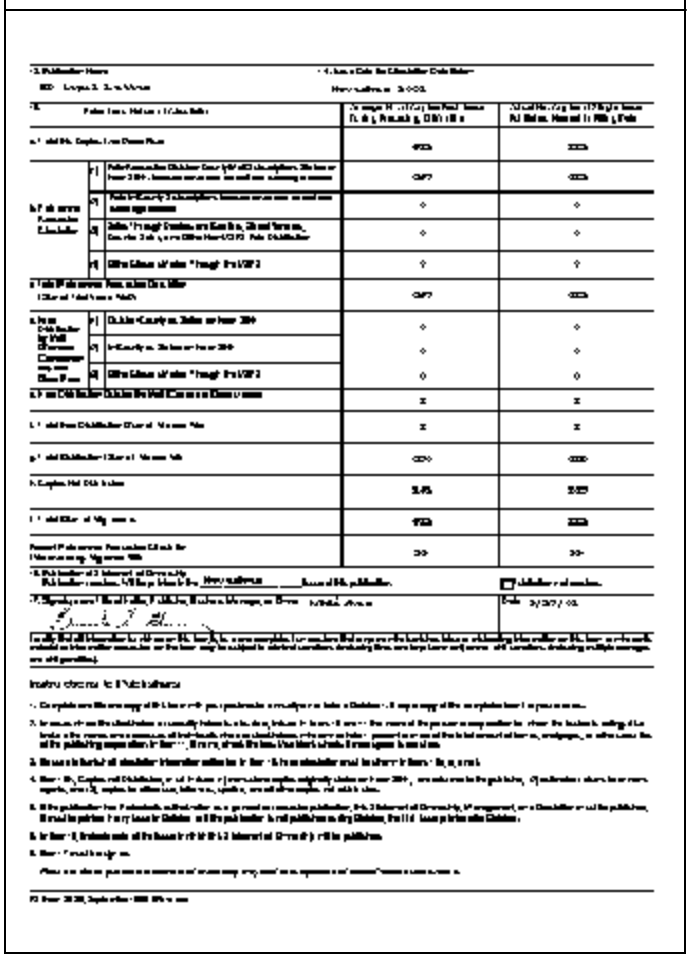

46. *Id*. at 993.
47. *Id*. at 994. The court here citing *Repp v. Anadarko Municipal Hosp.*, 43 F.3d 519, 522 (10th Cir.1994).
48. *Id*. at 995.
49. The court here citing EMTALA statute 42 U.S.C. § 1395dd(e)(4).

CE/CME Questions:

A note to* ED Legal Letter *subscribers:

Starting this December, CE/CME testing will be in the December and June issues instead of October and April. We made the change in response to subscriber complaints that the previous testing cycle was inconvenient.

That means your next issue, December, will include a Scantron form to return with test answers. That test will cover eight issues and offer eight CME credit hours or nursing contact hours. Future testing cycles will be the standard six issues with six credits.

To thank you for your loyalty to the newsletter, we have enclosed a FREE copy of Trauma Reports *in this issue. This special issue offers you the opportunity to earn an additional 2.5 CME credits immediately. The answer sheet in this issue is only for use with* Trauma Reports. *An answer sheet covering* ED Legal Letter *issues from April to December will be in next month's issue. If you have questions about this change or about your subscription, please call our customer service department at 1-800-688-2421.*

25. Under EMTALA, the medical screening exam:
    A. is used to determine if an emergency medical condition exists.
    B. establishes a standard of care nationwide for physicians to screen patients.
    C. determines priority level of a patient; i.e., whether a patient needs more than triage to be evaluated.
    D. is required only for the uninsured or indigent.
26. When does a patient fulfill the "comes to" the hospital provision of EMTALA?
    A. When the patient is anywhere on hospital property, including hospital property 250 yards surrounding the main campus
    B. When the patient is in a hospital-owned ambulance
    C. When he or she is in a non-hospital-owned ambulance that contacts the hospital through telemetry
    D. All of the above
27. EMTALA requires:
    A. stabilizing of only those conditions that are discovered during a reasonable screening exam.
    B. screening of only physical not psychiatric conditions.
    C. physicians to report an inappropriate transfer.
    D. only that ED physicians provide a medical screening exam.
28. All of the following are included in EMTALA *except*:
    A. penalties for physicians who are on-call and refuse to evaluate/ stabilize a patient or who fails to respond within a reasonable time.
    B. a financial penalty of up to $50,000 for physicians for each violation.
    C. ability of patients transferred prior to stabilization of their emergency medical condition to sue the physician directly for an EMTALA violation.
    D. a requirement for hospitals to provide stabilizing treatment that is within the ability of that facility, including the use of ancillary services.

CE/CME Objectives

[For information on subscribing to the CE/CME program, contact customer service at (800) 688-2421 or e-mail customerservice@ahcpub.com.]

The participants will be able to:

- identify high-risk patients and use tips from the program to minimize the risk of patient injury and medical malpractice exposure;
- identify a "standard of care" for treating particular conditions covered in the newsletter;
- identify cases in which informed consent is required;
- identify cases in which there are reporting requirements;
- discuss ways in which to minimize risk in the ED setting.

Accreditation Statement

American Health Consultants is accredited as a provider of continuing education in nursing by the American Nurses Credentialing Center's Commission on Accreditation. Provider approved by the California Board of Registered Nursing, Provider Number CEP 10864 for approximately 1 contact hour.

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American Health Consultants is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

At the conclusion of this audio conference, participants will be able to list ways in which they can help their hospitals comply with EMTALA.

In Future Issues:

Pediatric Medicolegal Issues

The CMS Question and Answer Report

To better inform hospitals of their obligations under our current regulations, in July 2001, the Centers for Hedicare and Medicaid services (CMS) released a set of 25 questions and answers relating to implementation of regulations concerning EMTALA. Some pertinent questions that affect ED physicians include are described in detail below; others are addressed in the table that follows.

The 250-Yard Rule. In helping define the requirements of the hospital regarding its campus, CMS posed the question: "Is a hospital obligated to comply with EMTALA whenever an individual presents for emergency medical care anywhere within 250 yards of the hospital's main building, even in an area that is not hospital-owned and -operated?"

CMS answered "no." Generally, a hospital campus is defined in regulations as the physical area immediately adjacent to the hospital's main buildings, other areas and structures that are not strictly contiguous to the main buildings, but are located within 250 yards of the main buildings, and any other areas determined on an individual case basis by the CMS regional office to be part of the hospital campus.[1] "We consider the parking lot, sidewalk, and driveway that are on hospital property to be part of the hospital for EMTALA purposes," the CMS reported.[2] For purposes of EMTALA, the parameters of a hospital's campus are not determined by drawing a circle 250 yards around a hospital's main building and concluding that every area and structure that happens to be located within those boundaries is part of the hospital campus.

For EMTALA purposes, an individual seeking emergency care who presents to a location on the hospital campus as interpreted above will be considered to have "come to the hospital" if a request is made on the individual's behalf for emergency care.

When Is EMTALA Triggered? Another question of significant importance is: When is EMTALA triggered in the hospital ED and on hospital property other than in the ED? CMS answered: An EMTALA screening obligation on the part of the hospital is triggered in one of two ways: first, when the individual presents at a hospital's ED and requests examination or treatment for a medical condition; and second, when the individual presents elsewhere on hospital property (that is, at a location that is on hospital property but is not part of a recognized ED) and requests examination or treatment for an emergency medical condition.

CMS noted that a hospital also would incur an EMTALA screening obligation if the individual was not able to make a verbal request, but showed symptoms that indicated the obvious possibility of an emergency medical condition. This policy does not require that an emergency medical condition be diagnosed upon subsequent medical examination. Rather, it requires only that in the absence of a request for examination or treatment of an emergency medical condition, a prudent layperson observer would believe, based upon the individual's symptoms, that the individual needs emergency care.[3]

CMS used the following example for clarification: While undergoing scheduled physical therapy in an off-campus, provider-based outpatient department of a hospital, a patient complains of chest pains and lightheadedness for which she requests assistance. A nurse, who has been designated by the hospital as a qualified medical person for purposes of EMTALA, screens the patient for signs of an emergency medical condition and decides that the patient must be transported to the main hospital's ED to complete the screening examination. In the ED, the patient is given a medical screening examination which reveals that she has an emergency medical condition related to coronary artery disease. She is stabilized in the emergency department and is released to the care of her daughter.

Analysis: In this case, the hospital is obligated to comply with the EMTALA requirements because the patient had presented at the off-campus provider-based outpatient department and requested examination or treatment for an emergency medical condition by complaining of the chest pains and lightheadedness. The hospital would have incurred the same EMTALA obligation if the patient had presented at a hospital department located on the main campus, rather than at the off-campus location, and requested examination or treatment for an emergency medical condition; if she had not made a verbal request, since her symptoms of a possible heart attack indicated an obvious possibility of an emergency medical condition; and even if her symptoms were later shown to result from a non-emergency condition.

The case example obviously was not written by physicians. The identification of an emergency medical condition does not end the requirements of EMTALA. The patient with chest pain due to coronary artery disease (unless it is chronic stable angina) is not stabilized, and therefore discharged to the care of her daughter

would not be appropriate under EMTALA (nor would it be standard of care).

When Outpatients Present for Treatment. Another question posed: If the outpatient setting is an "urgent care center/walk in" clinic that also sees patients by appointment, is it correct that only patients who present for examination or treatment for emergency medical conditions must be triaged and re-prioritized according to presenting symptoms, as would be done in the hospital ED?

The answer is "yes." However, whether in an off-campus department, an on-campus department, or a hospital ED, it is never appropriate simply to "triage" an individual who is presenting for examination or treatment for an emergency medical condition. As discussed below, the hospital (using the capabilities of the off-campus site and, as appropriate, the ED) must screen the individual presenting in this manner. We would expect a hospital ED and the outpatient department to prioritize the screening/stabilization based upon the individuals presenting at that location, and that screening/stabilization in an outpatient department (either on the hospital campus or in an off-campus location) would not be delayed due to the outpatient department's non-emergency caseload. In instances when the appropriate staff initiate the screening and determine that an emergency does not exist, no additional treatment would be required under EMTALA. ■

Endnotes

1. CMS citing 42 CFR § 413.65(a)(2). A complete copy of CMS question and answer guide can be found at Medicare Learning Network at www.hcfa.gov/medlearn/emqsas/htm. (Accessed 10/30/01.)
2. CMS citing 42 CFR § 489.24(b).
3. CMS Question and answer guide, question #2.

CMS Question and Answer Guidelines

Q: *Is a hospital permitted to maintain separate on-call lists for its main campus and an off-campus department, so that physicians may agree to come in to the main campus when called, but refuse to respond to calls from the remote location?*

A: CMS answered, yes. However, if a patient is transported from the off-campus department to the main hospital ED and a physician on the main campus on-call list is called to come in to treat the patient at the main campus, he or she is obligated to do so. (This has important implications to on-call physicians who frequently question their obligation not only to the off-site campus but also to the region.)

Q: *Are hospitals required to adopt protocols for ED staff to be dispatched to an off-campus department to treat a patient, or can this be decided on a case-by-case basis?*

A: The preamble to the regulations indicates that hospitals may arrange to dispatch ED staff to other locations to address emergency cases. However, protocols requiring such arrangements are not required. The decision in such cases should be based on the specific situation and on the medical condition and needs of the patient.

Q: *Can a hospital decline to designate any staff as qualified medical persons (QMPs) in an off-campus department routinely staffed by physicians, RNs, or LPNs, because it believes the staff of that particular department would not meet its qualification requirements to serve as QMPs in the main campus ED?*

A: No, the regulations specify at 42 CFR § 489.24(i)(2)(i) that in such departments, at least one individual at the off-campus department during its regular hours of operation must be a designated QMP.

Q: *The current interpretive guidelines regarding signage in EDs and "other places in the hospital that a person might go seeking emergency medical treatment" might be misinterpreted by some individuals to mean that all screening and stabilization must be conducted at the off-site department, without the need to move the individual to the main campus ED. Can the wording of the signs be modified to avoid confusion on this point?*

A: The current signage requirement does not state, and is not intended to imply, that a complete emergency medical screening will be conducted at the off-campus department. The hospital has a responsibility to its patients to inform them as to their rights under EMTALA. The services rendered are dependent upon the capability and capacity of the off-campus department and the hospital. Any off-campus department where patients may wait for examination or treatment for an emergency medical condition must adhere to the minimal signage requirements at the hospital according to the regulations at 42 CFR § 489.20 (q).

Q: *The EMTALA regulations impose various requirements on hospitals with EDs (e.g., log maintenance, arranging for transportation or transfer, forwarding medical records); is it acceptable to view these as obligations of the hospital as a whole and allow each hospital to design its own most effective way to meet the requirements?*

A: Yes, hospitals are responsible for compliance at all hospital locations. Therefore, main hospital resources must be available to help the hospital's off-site departments comply with EMTALA requirements.

ED Legal Letter
The Essential Monthly Guide to Emergency Medicine Malpractice Prevention and Risk Management
From the publishers of Emergency Medicine Reports and ED Management

CE/CME Test Questions May - October 2001

May 2001

1. Appropriate outpatient follow-up for a patient discharged from the ED with possible appendicitis should be in:
   A. hours.
   B. one day.
   C. 2-3 days.
   D. None of the above

2. Your chances of prevailing in a malpractice lawsuit alleging the failure to diagnose appendicitis will be enhanced by:
   A. a meticulously documented complete history and physical examination.
   B. well-documented discharge instructions providing for close follow-up.
   C. use of surgical consultation when appropriate.
   D. All of the above

3. Which of the following, if any, is essential in every patient presenting with a complaint of abdominal pain?
   A. CBC
   B. CT scan
   C. ultrasound
   D. None of the above

4. Patients who create a high risk for missing the diagnosis of appendicitis include:
   A. pregnant women.
   B. the very young.
   C. the elderly.
   D. All of the above

June 2001

5. Under certain circumstances, medical control immunity statutes shield physicians and certain nurses from which of the following?
   A. Criminal culpability
   B. Civil liability
   C. Filing of a lawsuit
   D. Termination

6. Because of the indirect relationship that exists between a medical control physician and a patient treated in the field by EMS personnel, most courts would rule that malpractice on the part of the physician may exist only when the physician has engaged in which of the following activities?
   A. Litigation
   B. Hands-on treatment
   C. Diagnosis and treatment recommendation
   D. Radio communication

7. A medical control physician *not practicing in the Ninth Circuit* who orders an incoming ambulance to divert away from his or her ED, prior to the ambulance entering hospital property, will likely be violating EMTALA **only** if:
   A. the ambulance is owned and operated by his or her hospital.
   B. the patient is indigent.
   C. the physician is board-certified in emergency medicine.
   D. every bed in the ED is filled.

8. A physician who provides medical direction to an EMS service might, as a result of this activity, incur civil liability for which of the following?
   A. Battery
   B. Medical malpractice
   C. Both A and B
   D. None of the above

July 2001

9. In dextrose infiltration, the following are true *except:*
   A. Loose dressings, elevation, and cold packs to the area are indicated.
   B. Warm soaks should be avoided.
   C. Injection of hyaluronidase at the site of extravasation has been shown to be harmful.
   D. Large veins should be used for the infusion when possible.

10. All of the following statements are true *except:*
    A. Extravasation rates vary from 23%-28% of all patients receiving IV therapy.
    B. The "classic" initial signs and symptoms of extravasation are swelling, burning, tightness, blanching, and coolness.
    C. The more severe and late manifestations of extravasation injuries are blister formation, ulceration, skin necrosis, compartment syndrome, and reflex sympathetic dystrophy syndrome.
    D. The IV should be properly secured with tape, covered with gauze, and wrapped in webroll or a gauze dressing.

11. Treatment of phenytoin extravasations injuries includes all of the following *except:*
    A. Immediate discontinuation of the infusion once detected, and

aspiration of all residual fluid in the tubing and syringe.
B. Discontinuation of all use of that extremity until complete resolution of symptoms.
C. The extremity should be elevated and splinted to reduce edema, and dry heat should be applied to help redistribute the phenytoin throughout the forearm.
D. Moist heat is indicated because it can reduce skin breakdown.

12. All of the following statements regarding the treatment for dopamine or other vasopressor extravasation injuries are true *except:*
A. Phentolamine, which competitively blocks the alpha-adrenergic receptors, is the treatment of choice for vasopressors.
B. Phentolamine at 0.5 mg/mL is most effective if given within the first 12 hours of extravasation.
C. The use of transdermal glyceryl trinitrate patches has been successful in treating ischemic areas to increase perfusion post extravasation.
D. Subcutaneous hyaluronidase injection is the treatment of choice.

August 2001

13. Failure to file a timely answer to a complaint may result in:
A. a default judgment against the defendant.
B. admissions to the allegations made.
C. the granting of a motion for summary judgment.
D. None of the above

14. Typical discovery methods include *all but which* of the following?
A. Interrogatories
B. Requests for production
C. Motions in limine
D. IMEs

15. Questions of fact to be decided by the jury include *all but which* of the following?
A. Breach of the standard of care
B. Amount of compensatory damages
C. Admissibility of expert testimony
D. Proximate cause

16. In most states, the burden of proof in a malpractice case is:
A. beyond a reasonable doubt, and lies with the defendant.
B. beyond a reasonable doubt, and lies with the plaintiff.
C. by a preponderance of the evidence, and lies with the defendant.
D. by a preponderance of the evidence, and lies with the plaintiff.

September 2001

17. A work-up of a headache patient in the ED should always include:
A. complete problem-focused history.
B. neurological examination.
C. lumbar puncture.
D. Both A and B

18. Which of the following statements is *false?*
A. Most cerebral aneurysms that cause subarachnoid hemorrhage (SAH) arise from arteries located in the circle of Willis.
B. Approximately 35% of cerebral aneurysms arise from the anterior circulation.
C. When ruling out SAH, a negative CT scan should be followed by a lumbar puncture.
D. A lumbar puncture is more sensitive than a CT scan for the detection of SAH.

19. Which of the following statements is true regarding SAH?
A. SAH is more common in women.
B. A family history of SAH in a first-degree relative is a risk factor for SAH.
C. A prior SAH is a risk factor for a subsequent SAH.
D. All of the above

20. Appropriate questions to ask a patient presenting to the ED with headache include:
A. When and where did the pain start and how has it progressed?
B. Have you had similar, or worse, headaches in the past?
C. Have you had a fever?
D. All of the above

October 2001

21. Under certain circumstances, Good Samaritan statutes shield defined classes of health-care providers from which of the following?
A. Criminal culpability
B. Civil liability
C. Immunity from a federal civil rights claim
D. Termination

22. In most jurisdictions, a health care provider who voluntarily renders emergency medical care at the scene of an emergency is immune from liability arising from which type of conduct?
A. Gross negligence
B. Ordinary negligence
C. Willful misconduct
D. Wanton misconduct

23. A health care provider, such as a doctor or a nurse, generally *does not* qualify for Good Samaritan immunity when which of the following exists?
A. Pre-existing duty to respond
B. Ordinary negligence
C. Life-threatening emergency
D. Vicarious liability

24. Which of the following is *not necessary* to trigger Good Samaritan immunity in most jurisdictions?
A. Emergency situation
B. Voluntary action
C. Administration of emergency care
D. Pre-existing duty to respond