THE SULLIVAN GROUP

# TSG Quarterly Report

At the crossroads of law and medicine

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**Editor's Note**: Well CMS has complicated our lives again! The new Interpretive Guidelines are out and are addressed at length in this newsletter. I have made multiple calls to the CMS EMTALA staff in Washington to get clarification regarding several confusing issues. They have been very responsive and quite helpful. Please get back to us with any feedback and thoughts you may have on the new guidelines.

All of the TSG EMTALA web-based courses (CME, CE, administrative and on-call physician) will be updated based on the new Interpretive Guidelines by July 15th.

As always, the newsletter needs your continued support. Please share interesting medical or malpractice cases, EMTALA cases, and any medical-legal issues that may arise in your practice of emergency medicine.

Finally, join me in welcoming Jim Hubler, MD, JD, FACEP to our editorial staff. Jim has been the Executive Editor of the ED Legal Letter for over two years and will be an invaluable addition to our team.

Daniel J. Sullivan, MD, JD, FACEP

## In This Issue



# Emergency Medicine Malpractice Case Reporter

By Dan Sullivan, MD, JD, FACEP

### Case Overview

The following is a review of a medical malpractice case. The case went to trial and to a jury verdict. The case demonstrates several critical issues with regard to the particular clinical entity and also the emergency department (ED) as a system.

A 58-year-old male presented to the emergency department complaining of upper abdominal pain. The patient was triaged at 11:05 AM. The triage nurse noted that the patient had chest pain 3 days prior but now had epigastric abdominal pain. No radiation. The patient did not smoke. Past medical history included hypertension, he could not remember the names of his medication. Vital signs: pulse 100; respiratory rate 20; blood pressure 110/70; temperature 98.0.

The patient was placed into a stretcher space at 11:30 AM and was seen by the emergency physician at 11:40 AM. The patient told the emergency physician that he had chest pain 3 days prior and had never had a problem like that before. Other than the hypertension, he had no past medical history. The physician noted that the patient was on a calcium channel blocker.

The chest pain was not associated with shortness of breath, nausea, vomiting, or sweating. It had come and gone a few times on that first day and he felt it once 2 days prior to this visit. The patient presented to the department because of a moderate to severe constant epigastric pain; the chest pain had completely resolved. The abdominal pain did not radiate to the back. He had no prior surgical history. No history of blood in his stool. No pain elsewhere in the abdomen. No history of fever. The only risk factor for coronary artery disease was the HTN. The physician immediately ordered an ECG even before his physical examination. Review the ECG below.

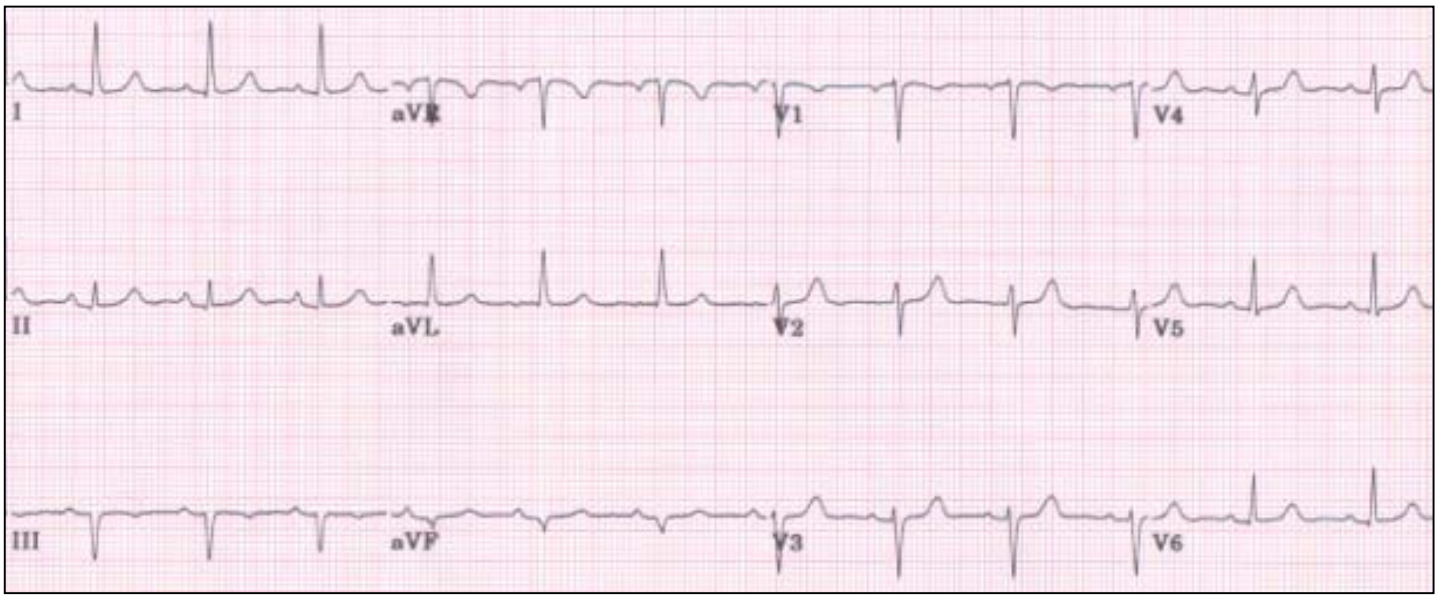


**Figure 1**

Take a closer look at the limb leads.

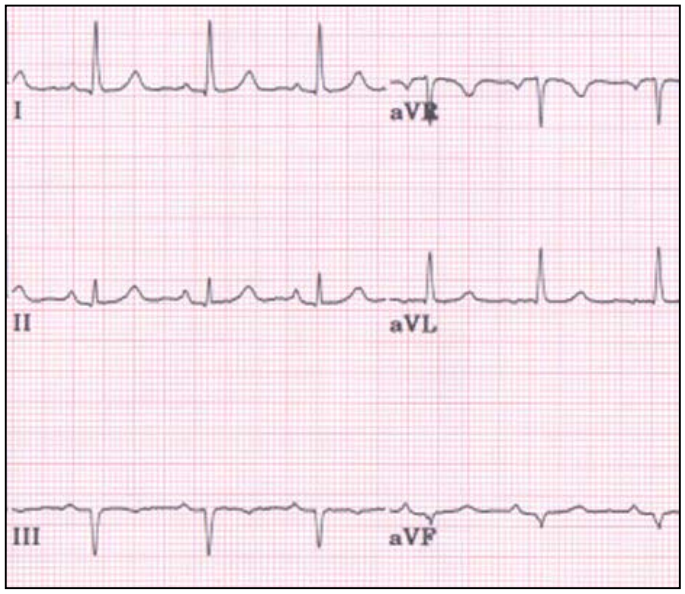


**Figure 2**

On physical examination, the emergency physician noted he had reviewed the nursing vitals, and the patient appeared to be in pain. The abdominal pain was 5 on a scale of 10. Normal mental status, alert and oriented X 3. HEENT was normal. Neck supple. Chest was clear, no rales or rhonchi. The heart sounds were normal, no murmur, no extra heart sounds. No chest wall pain. The abdomen was non-tender. No guarding or rebound.

Take a closer look at the chest leads.

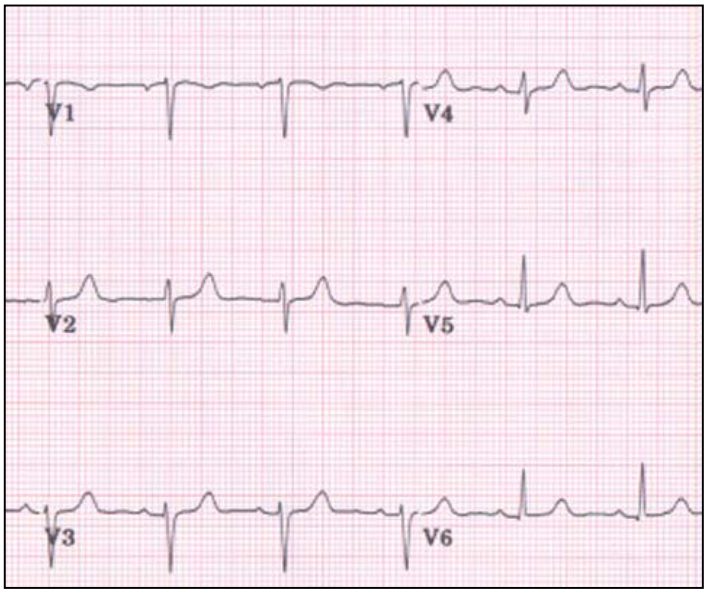


**Figure 3**

There was no pulsatile abdominal mass. Bowel sounds were normal. Distal pulses were intact. Extremities were normal and the neurologic exam was normal.

The physician ordered the following tests: Chest X-Ray; Complete Blood Count; Basic Metabolic Profile; Cardiac Markers; Coagulation Studies; Amylase and Lipase; Liver

Function Tests; Urinalysis. These orders were entered the by ED clerk at 12:10 PM.
The emergency physician wrote an order for the nurse to administer a GI cocktail. The GI cocktail was administered at 12:20 PM. The nursing progress note entry from 12:45 states that the patient was more comfortable, with the pain now 3 on a scale of 10. That same progress note contains the following repeat vital signs: pulse 100; respiratory rate 20; blood pressure 105/60.

The deposition and court testimony indicate that at this time, the emergency physician was considering the possibility of peptic ulcer disease, gastro-esophageal reflux disease, and coronary artery disease. The physician interpreted the ECG as demonstrating non-specific changes. The portable chest X-Ray appeared normal. The emergency physician's 'wet reading' was normal heart size, no infiltrate. This was later confirmed by the radiologist.

The labs began returning around 1:00 PM. The electrolytes and blood sugar were normal; BUN and creatinine were normal. The initial set of cardiac markers, Troponin and CPK MB, were normal. The Troponin level was 0. The CBC revealed a hemoglobin of 12; normal for the lab for males was 14 to 16. Coagulation studies were normal.

There is a nursing progress note from 1:15 PM which indicates that the patient was restless, pain was 5 on a scale of 10, and repeat vitals revealed the following: pulse 106; respiratory rate 24; blood pressure 96/50. The nurse also noted, "Physician aware of vitals." The physician ordered an IV infusion of normal saline, 500 cc bolus and 250 ccs per hour. The patient's blood pressure improved following the fluid infusion.

The physician's testimony indicates that at around 1:15 PM, based on the labs and on the blood pressure, she began to consider the possibility of an abdominal aortic aneurysm or a thoracic aortic dissection. She wrote an order for a CT of the chest and abdomen with infusion on the ED order sheet and gave it to the clerk. The order was not timed.

The emergency physician testified that at around 3:30 PM she checked for the CT results, only to find that the patient had not ever gone for CT scan. She further testified that she then spoke with the clerk and the primary nurse and discovered that the order had never been entered.

The ED clerk testified that the physician did not give her the order for the CT scan until 3:30 PM. The nurse testified she was not aware of the physician's intention to obtain a CT scan and knew nothing about the orders.
The CT order was entered at 3:35 PM. The patient was immediately taken down to the CT scan facility. During the CT scan the patient dropped his blood pressure. The technician called the emergency physician down to assist in resuscitation at 3:50 PM. The patient was resuscitated and returned to the ED at 4:10 PM. The CT was never completed.

The emergency physician called the cardiovascular surgeon for a presumed dissection or abdominal aortic aneurysm. The cardiovascular surgeon arrived at 4:30 PM and got the patient to the operating room, but the patient arrested prior to surgery and could not be resuscitated. The patient was pronounced dead at 4:58 PM.

The autopsy revealed a thoracic aortic dissection, Debakey Type 1 or Stanford Type A. The dissection began in the ascending aorta and had dissected well down into the abdominal aorta.

## The Litigation

Among a long list of items, the family sued the emergency physician for:

1. The failure to timely recognize the dissection.
2. The failure to promptly order a CT scan.
3. Delay in management of the dissection.
4. Failure to provide early consultation by a cardiovascular surgeon in a patient with symptoms of dissection and low blood pressure.

The family sued the hospital for:

1. The clerk's failure to enter the CT scan order when it was written at 1:15 PM.
2. The nursing failure to cause the CT scan to be done in a timely manner.

The plaintiff's emergency medical expert testified that the diagnosis of dissection should have been apparent based upon the history of chest pain moving into the abdomen and the relatively low blood pressure in a patient with known hypertension. He further testified that the physician was obligated to be certain that the CT order was appropriately entered, or in the alternative, that she did not order the CT scan at 1:15 PM, but in fact did not order it until 3:30 PM. The plaintiff's emergency medicine expert testified that the delay in getting the CT scan resulted in a delay in surgical intervention and the patient's death.

The plaintiff's cardiovascular surgical expert testified that if the diagnosis had been made anytime prior to 3:45 PM, a cardiovascular surgeon would have been able to operate and the patient would have had over an 80% chance of survival.

The defense emergency medical expert testified that the physician's work-up and management was appropriate. It was appropriate to evaluate the patient for possible coronary artery disease, and that when the patient's blood pressure dropped and the hemoglobin level came back abnormally low, it was appropriate to order the CT scan at 1:15 PM. He further testified that it was more likely than not that the emergency physician did order a CT scan at that time, because based on the medical record and the emergency physician's deposition, CT was the obvious next step in management; he also testified that there was probably an error at the clerk's desk and a failure to recognize the need to enter the order.

The clerk testified at trial that the process of order entry is very straightforward and there was no way she would have missed that order. Further, she testified that the first time the physician gave the order was at 3:30.

The physician testified in court that she absolutely wrote the order at 1:15 PM and gave it to the clerk; further, that there must have been a problem with order entry or the clerk never entered the order. The physician testified that a CT of the chest and abdomen should have been accomplished by no later than 2:00 PM, and then the patient would have been in the operating room by 3:00 PM.

The jury deliberated for 11 hours and ultimately concluded that they believed the clerk, not the emergency physician. They found that the physician's delay in ordering the test resulted in the patient's death. The jury awarded the plaintiff $3,000,000.

## Discussion

It is extremely difficult for the defense to win a malpractice case when the physician and hospital are pointing the finger at each other. The plaintiff can sit back and see who wins. In either case, the plaintiff benefits. It was very clear to all parties that this case would come down to who the jury believed. If the physician was right, then the hospital breached a standard of care for timely order entry. If the clerk was right, then the physician delayed definitive management.

There are many teaching points in this unfortunate case.

1. **Communication**. Assume for a moment that the physician was correct and that this was clerical error. Effective communication is at the core of quality emergency medical care. Problems with effective communication are often found as the cause of medical errors and patient harm. This is just one of many examples in inadequate communication. Anyone with experience in the emergency department is aware that the ED clerical position is a monumental multi-tasking proposition. It is amazing to watch what an ED clerk does over the course of a shift. The ED team must carefully craft a system solution to this type of problem.

   Fortunately, solutions are on the way. Several of the new electronic information systems allow physician order entry, taking the ED clerk out of the equation. The solution is quite simple. Take all unnecessary steps out of the process. Today the physician checks a box or writes the name of a test in longhand, walks over to the clerk, the clerk gets to the chart when there is time, identifies the order, calls it up on the computer screen, and enters the order. Electronic systems provide for order entry at the moment the physician checks the box. Electronic systems are slowly making their way into emergency departments. In the meantime, consider modifying your clerical order entry so that there is some kind of feedback loop to assure compliance.

2. **Aortic Dissection**. The patient's initial presentation was actually consistent with a dissection. Perhaps that diagnosis should have been in the differential at some point earlier than 1:15 PM. The pain started in the chest, came and went, and then moved into the abdomen. This is completely consistent with an aortic dissection, as the dissection process starts in the ascending aorta and then moves into the descending aorta and below the diaphragm. Malpractice case review suggests that clinicians often do not recognize this migration of pain. This is not radiation, but rather a migration of pain from the chest to the abdomen or lower back.

   In addition, the patient had a relatively low blood pressure since he had a history of hypertension. This physical finding coupled with the presenting history should put dissection into the differential diagnosis. CT imaging could have occurred much earlier in the day.

3. **Risk History**. The physician should have asked and documented a risk factor analysis for high-risk clinical entities that cause chest and/or epigastric pain. In general, physicians tend not to perform an adequate risk analysis for dissection, abdominal aortic aneurysm, subarachnoid hemorrhage and other high risk diagnoses. It is not clear that the patient had any risk factors other than hypertension, but this analysis can provide an early opportunity to make a diagnosis. For example, if this patient had had a first degree relative with a dissection, that could have resulted in an early diagnosis.

4. **Bilateral Blood Pressure**. This would have been a valuable addition to the physical examination. This test is seldom performed or documented by physicians in chest/epigastric pain cases. This may not be a standard of care, but certainly indicates that the physician considered the possibility of dissection. It is an important element in communicating the physician's differential diagnosis.

5. **Judgment Beyond Policy Limits.** Every physician's nightmare. The physician had a million dollar limit and her corporation had a million dollar limit. The judgment was entered against the physician only, not the hospital. Therefore the judgment was one million dollars in excess of policy limits. This is an unusual situation in emergency medicine. Judgments and settlements typically fall within policy limits or are negotiated within policy limits, sometimes even post judgment. This raises the important issue of asset protection as a physician risk management strategy. There are attorneys that specialize in asset protection, and much can be done to protect your personal assets.

# EMTALA Update – New Interpretive Guidelines Outline Hospital Responsibilities

By Jim Hubler, MD, JD, FACEP, FAAEM, FCLM

On May 13, 2004, the Department of Health & Human Services, Centers for Medicare & Medicaid Services (CMS) issued the "Revised Emergency Medical Treatment and Labor Act (EMTALA) Interpretive Guidelines." These Interpretive Guidelines detail the responsibilities of Medicare participating hospitals in emergency cases. These guidelines are to be used by the regional offices and state Survey Agencies during an investigation, and they reflect the final rule changes posted in September 2003. These guidelines contain clarifications of statutory and regulatory requirements and are to be used to assist in making consistent determinations about a provider's compliance with the requirements of EMTALA. Hospitals need to reference the Final Rules and Interpretive Guidelines and make necessary policy changes to prepare for the unexpected EMTALA investigation. A complete list of the latest rules and regulations can be found on the TSG website. Simply go to www.thesullivangroup.com and click on the 'EMTALA' button located on the upper navigation bar. Compliance will avert potential fines or termination of a hospital's Medicare provider agreement. This issue of the TSG Newsletter specifically references these Interpretive Guidelines.

## I. Overview Hospital Responsibilities

Medicare participating hospitals must provide a medical screening examination to any individual who comes to the emergency department and requests such an examination, and hospitals with emergency departments are prohibited from refusing to examine or treat individuals with an emergency medical condition (EMC). The provisions of EMTALA apply to all individuals (not just Medicare beneficiaries or the uninsured/indigent) who attempt to gain access to a hospital for emergency care. If the results of an investigation indicate that a hospital violated EMTALA, a hospital may be subject to termination of its provider agreement and/or the imposition of civil monetary penalties. Civil monetary penalties may be imposed against hospitals or individual physicians for violations. Immediate jeopardy violations, those with significant risk to patient safety, require a 23-day termination track. Non-immediate jeopardy violations require a 90-day termination track.

### A. Dedicated Emergency Department Defined

The newest regulations define "hospital with an emergency department" to mean a hospital with a dedicated emergency department. The regulations define "dedicated emergency department" as any department or facility of the hospital that either:

> *1) is licensed by the state as an emergency department;*
> *2) is held out to the public as providing treatment for emergency medical conditions; or*
> *3) where one-third of the visits to the department in the preceding calendar year actually provided treatment for emergency medical conditions on an urgent basis.*

The first two definitions are clear enough but the third may be confusing. The new guidelines provide a formula for this calculation. Essentially the reviewer will look to the prior calendar year and take a sample of 20 to 50 patients from a log. The reviewer will then determine how many of those patients 1) were outpatients; and 2) were walk-ins or unscheduled patients; and 3) had an emergency medical condition and received stabilizing treatment. If those patients represent over 1/3 of the total patients sampled then the entity will be deemed a dedicated emergency department.

Hospitals with dedicated emergency departments are required to comply with all aspects of EMTALA regulations. It is important to recognize that the new definition of a dedicated emergency department is an objective standard. It is not enough that a patient presents and believes that this may be a place that provides emergency medical services.

### B. Reporting Suspected Violations

Hospitals (not physicians) are required to report to CMS or the state survey agency promptly when it suspects it may have received an improperly transferred individual. Notification should normally occur within 72 hours of the occurrence. Failure to report improper transfers may subject the receiving hospital to termination of its provider agreement. If a recipient hospital fails to report an improper transfer, the hospital may be subject to termination of its provider agreement.

Surveyors are to look for evidence that the recipient hospital knew or suspected the individual had been to a hospital prior to the recipient hospital and had not been transferred in accordance with EMTALA. Evidence may

be obtained in the medical record or through interviews with the individual, family members or staff. Investigators will review the emergency department log and medical records of patients received as transfers. Specifically the investigators will look for evidence that:

- the hospital had agreed in advance to accept the transfers;
- the hospital had received appropriate medical records;
- all transfers had been effected through qualified personnel, transportation equipment and medically appropriate life support measures; and
- the hospital had available space and qualified personnel to treat the patients.

## II. What the Regional Offices and State Survey Agency Will be Looking for During Their Investigation

All investigations will be unannounced. The investigation is based on an allegation of noncompliance. The purpose of the investigation is to ascertain whether a violation took place, to determine whether the violation constitutes an immediate and serious threat to patient health and safety, to identify any patterns of violations at the facility, and to assess whether the facility has policies and procedures to address the provisions of the EMTALA law.

### A. Staffing Issues

A hospital must formally determine who is qualified to perform the initial medical screening examinations, i.e., qualified medical person. While it is permissible for a hospital to designate a non-physician practitioner as the qualified medical person, the designated non-physician practitioners must be set forth in a document that is approved by the governing body of the hospital. Those health practitioners designated to perform medical screening examinations are to be identified in the hospital by-laws or in the rules and regulations governing the medical staff following governing body approval. It is not acceptable for the hospital to allow the medical director of the emergency department to make what may be informal personnel appointments that could frequently change.

Investigators will look at staffing issues of the emergency department. If it appears that a hospital with a dedicated ED does not have adequate staff and equipment to meet the needs of patients, an expanded investigation may ensue.

### B. What Will Be Reviewed By Investigators

During the investigation, surveyors will ask the CEO to have the staff provide them with the following information (as appropriate):

- Dedicated ED logs for the past 6 to12 months;
- Dedicated ED policy/procedures manual;
- Consent forms for transfers of unstable individuals;
- Dedicated ED committee meeting minutes for the past 12 months;
- Dedicated ED staffing schedule (physicians for the past 3 months and nurses for the last 4 weeks) or as appropriate;
- Bylaws/rules and regulations of the medical staff;
- Minutes from medical staff meetings for the past 6-12 months;
- Current medical staff roster;
- Physician on-call lists for the past six months;
- Credential files, specifically the director of the emergency department and emergency department physicians;
- Quality Assessment and Performance Improvement (QAPI) Plan (formally known as Quality Assurance);
- QAPI minutes (The portion of the quality improvement minutes and plan, which specifically relates to EMTALA regulations. If a problem is identified that would require a more thorough review, additional portions of the quality improvement plan and minutes may be requested for review.);
- List of contracted services;
- Dedicated ED personnel records (optional);
- In-service training program records, schedules, reports, etc. (optional review if questions arise through interview and record review regarding the staff's knowledge of EMTALA);
- Ambulance trip reports and memoranda of transfer, if available;
- Ambulance ownership information and applicable state/regional/community EMS protocols;
- Records will be reviewed for a three-month period surrounding the date of the alleged violation. A selection of sample of cases (medical records) may be reviewed from the ED log. (See Interpretive Guidelines pg. 7 for how sample size and selection will be determined during an investigation).

### C. Peer Review

While surveyors may make preliminary findings during the course of the investigation, a physician must usually determine the appropriateness of the medical screening exam (MSE), stabilizing treatment, and transfer. This represents great progress on the part of CMS. Previously, the American College of Emergency Physicians and others had complained that these determinations should be peer

reviewed by a physician. Investigators without medical backgrounds were inappropriately making incorrect determinations regarding the MSE and stabilizing treatment.

The guidelines state that the purpose of a professional medical review (physician review) is to provide peer review using information available to the hospital at the time the alleged violation took place. Physician review is required prior to the imposition of civil monetary penalties or the termination of a hospital's provider agreement. Physician review is needed to determine if:

- The screening examination was appropriate. Under EMTALA, the term "appropriate" does not mean "correct" in the sense that the treating emergency physician is not required to correctly diagnose the individual's medical condition. The fact that a physician may have been negligent in his screening of an individual is not necessarily an EMTALA violation. When used in the context of EMTALA, "appropriate" means that the screening examination was suitable for the symptoms presented and conducted in a non-disparate fashion. Physician review is not necessary when the hospital did not screen the individual.

- The individual had an emergency medical condition. The peer review physician should identify what the condition was and why it was an emergency (e.g., what could have happened to the patient if the treatment was delayed).

- In the case of a pregnant woman, if there was inadequate time to affect a safe transfer to another hospital before delivery or the transfer posed a threat to the health and safety of the woman or the unborn child.

- The stabilizing treatment was appropriate within a hospital's capability (note that the clinical outcome of an individual's medical condition is not the basis for determining whether an appropriate screening was provided or whether the person transferred was stabilized).

- The transfer was performed by qualified personnel and transportation equipment, including the use of medically appropriate life support measures.

- If applicable, the on-call physician's response time was reasonable.

- The transfer was appropriate for the individual because the individual requested the transfer or because the medical benefits of the transfer outweighed the risk.

### D. Refusals

In cases where an individual (or person acting on the individual's behalf) withdrew the initial request for a MSE and/or treatment for an EMC and demanded his or her transfer or demanded to leave the hospital, a signed informed refusal of examination and treatment form by either the individual or a person acting on the individual's behalf is required. Hospital personnel must inform the individual (or person acting on his or her behalf) of the risks and benefits associated with the transfer or the patient's refusal to seek further care. If the individual (or person acting on the individual's behalf) refused to sign the consent form, personnel must document that the individual refused to sign the form. The fact that an individual has not signed the form is not, however, automatically a violation of the screening requirement. It is important to note that the rules require the refusal to contain the *proposed screening exam* and the *potential treatment* that may be offered. Therefore, previous against medical advice forms which do not contain the *proposed screening* exam and *potential treatment* will be found inadequate. It would be appropriate for hospitals to add this to the format of their current against medical advice forms.

## III. On-Call Physicians

One of the biggest concerns of the medical staff is their responsibility for call: a list of physicians who are on call for duty after the initial examination to provide further evaluation and/or treatment necessary to stabilize an individual with an emergency medical condition. The on-call list identifies and ensures that the emergency department is prospectively aware of which physicians, including specialists and subspecialists, are available to provide care. A hospital can meet its responsibility to provide adequate medical personnel to meet its anticipated emergency needs by using on-call physicians either to staff or to augment its emergency department, during which time the capability of its emergency department includes the services of its on-call physicians.

### A. Frequency of Physician Call

CMS does not have requirements regarding how frequently on-call physicians are expected to be available to provide on-call coverage. Nor is there a pre-determined ratio CMS uses to identify how many days a hospital must provide on-call coverage based on the number of physicians on staff for that particular specialty. In particular, CMS has **no** rule stating that whenever there are at least three

physicians in a specialty, the hospital must provide 24 hour / 7 day coverage in that specialty. Generally, in determining EMTALA compliance, CMS will consider all relevant factors, including the number of physicians on staff, other demands on these physicians, the frequency with which the hospital's patients typically require services of on-call physicians, and the provisions the hospital has made for situations in which a physician in the specialty is not available or the on-call physicians is unable to respond. The provision of on-call coverage is a decision made by hospital administrators and the physicians who provide on-call coverage for the hospital. Each hospital has the discretion to maintain the on-call list in a manner to 'best meet the needs' of the hospital's patients who are receiving services required under EMTALA in accordance with the resources available to the hospital, including the availability of on-call physicians. The best practice for hospitals that offer particular services to the public is that those particular services should be available through on-call coverage of the emergency department. It is important to note that the physician's group names are **not** acceptable for identifying the on-call physician. Individual physician names are to be identified on the list.

No physician is required to be on call at all times. On-call coverage should be provided for within reason depending upon the number of physicians in a specialty. A determination about whether a hospital is in compliance with these regulations must be based on the facts in each individual case.

The Sullivan Group contacted CMS regarding the enforcement of these on-call requirements. CMS made it clear that it expects any specialty that has a significant presence on a medical staff, offers services to the community, and is available for inpatient care should be represented on the on-call schedule. If a specialty is not represented on the on-call schedule, during a review for any alleged EMTALA violation, CMS will be inquiring as to the specific reasons the specialty is not on the call schedule.

If a staff physician is on call to provide emergency services or to consult with an emergency room physician in the area of his or her expertise, that physician would be considered to be available at the hospital. *A determination as to whether the on-call physician must physically assess the patient in the emergency department is the decision of the treating emergency physician.* His or her ability and medical knowledge of managing that particular medical condition will determine whether the on-call physician must come to the emergency department. The physician must be the individual listed on the call list. However, his physician assistant, resident, or nurse practitioner may respond so long as this is provided in either the bylaws or rules and regulations of the hospital. The on-call physician is ultimately responsible for the individual regardless of who responds to the call. Again, the emergency physician may require attending physician presence.

Physicians that refuse to be included on a hospital's on-call list but take calls selectively for patients with whom they or a colleague at the hospital have established a doctor-patient relationship may violate EMTALA if at the same time they refuse to see other patients (including those individuals whose ability to pay is questionable). If a hospital permits physicians to selectively take call while the hospital's coverage for that particular service is not adequate, the hospital would be in violation of its EMTALA obligation by encouraging disparate treatment. Hospital resources and staff available to inpatients at the hospital for emergency services must likewise be available to individuals coming to the hospital for examination and treatment of an EMC because these resources are within the capability of the hospital.

If a physician on call does not fulfill his obligation to the hospital, but the hospital arranges for another staff physician in that specialty to assess the individual, then the hospital may not be in violation of the regulation if no other EMTALA requirements are violated. However, in this circumstance, the physician who has agreed to take call and does not come to the hospital when called may have violated the regulation.

CMS allows hospitals flexibility in the utilization of their medical personnel. Allowing exemptions from the call schedule for certain medical staff members (senior physicians) would not by itself violate EMTALA. This is permitted as long as there is adequate on-call coverage to best meet the needs of the hospital. Hospitals must have policies that define appropriate or adequate response times. Surveyors are to review the hospital policies or medical staff bylaws with respect to response time of the on-call physician. If a physician on the list is called by the hospital to provide emergency screening or treatment and either refuses or fails to arrive within the response time established by hospital policies or medical staff bylaws, the hospital and that physician may be in violation of EMTALA. Hospitals are responsible for ensuring that on-call physicians respond within a reasonable period of time. The expected response time should be stated in minutes in the hospital's policies. Terms such as "reasonable" or "prompt" are not enforceable by the hospital and are therefore inappropriate in defining a physician's response time.

### B. Office Visits and Elective Surgery While On Call

CMS still maintains that when a physician is on call for the hospital and seeing patients with scheduled appointments in his private office, it is generally not acceptable to refer emergency cases to his or her office for examination and treatment of an EMC. The physician must come to the hospital to examine the individual if requested by the treating emergency physician. If, however, it is medically appropriate to do so, the treating emergency physician may send an individual needing the services of the on-call physician to the physician's office if it is part of a hospital-owned facility (department of the hospital sharing the same Medicare provider number as the hospital) and on the hospital campus. In determining if a hospital has appropriately moved an individual from the hospital to the on-call physician's office, surveyors may consider whether (1) all persons with the same medical condition are moved in such circumstances, regardless of their ability to pay for treatment; (2) there is bona fide medical reason to move the patient; and (3) appropriate medical personnel accompany the patient.

Fortunately, CMS has seen the wisdom of allowing physicians to be on call at multiple hospitals simultaneously. Shortages of specialists and demands for coverage have led to a compromise of their previous position on the issue. Currently, for physicians taking call simultaneously at more than one hospital, the hospitals must have policies and procedures to follow when the on-call physician is not available to respond because he has been called to the other hospital to evaluate an individual. Hospital policies may include, but are not limited to, procedures for back-up on-call physicians or the implementation of an appropriate EMTALA transfer.

Physicians are not prohibited from performing surgery while on call. However, a hospital may have its own internal policy prohibiting elective surgery by on-call physicians to better serve the needs of its patients seeking treatment for a potential emergency medical condition. When a physician has agreed to be on call at a particular hospital during a particular period of time but has also scheduled elective surgery during that time, that physician and the hospital should have planned back-up in the event that he/she is called while performing elective surgery and is unable to respond to the situation or the implementation of an appropriate EMTALA transfer.

If a physician who is on call does not come to the hospital when called, but rather repeatedly or typically directs the patient to be transferred to another hospital where the physician can treat the individual, the physician may have violated EMTALA

## IV. The Medical Screening Examination

### A. MSE Defined

While initially the definition was somewhat elusive and applied inconsistently by courts and Regional Offices, there has been much more consistency and clarity regarding the MSE. Individuals coming to the emergency department must be provided a MSE beyond initial triaging. Triaging is not equivalent to a medical screening examination. Triage merely determines the "order" in which individuals will be seen, not the presence or absence of an emergency medical condition. "*A MSE is the process required to reach with reasonable clinical confidence, the point at which it can be determined whether a medical emergency does or does not exist.*" If a hospital applies in a nondiscriminatory manner (i.e., a different level of care must not exist based on payment status, race, national origin) a screening process that is reasonably calculated to determine whether an EMC exists, it has met its obligations under EMTALA. Depending on the individual's presenting symptoms, the MSE represents a spectrum ranging from a simple process involving only a brief history and physical examination to a complex process that also involves performing ancillary studies and procedures such as (but not limited to) lumbar punctures, clinical laboratory tests, CT scans, and/or diagnostic tests and procedures. A MSE is not an isolated event. It is an ongoing process. The record must reflect continued monitoring according to the patient's needs until he/she is stabilized, admitted or appropriately transferred. There should be evidence of this evaluation prior to discharge or transfer. The MSE must be the same MSE that the hospital would perform on any individual coming to the hospital's dedicated emergency department with those signs and symptoms, regardless of the individual's ability to pay for medical care. If the MSE is appropriate and does not reveal an EMC, the hospital has no further obligation under EMTALA.

Regardless of a positive or negative individual outcome, a hospital would be in violation of the anti-dumping statute if it fails to meet any of the medical screening requirements. The clinical outcome of an individual's condition is not a proper basis for determining whether an appropriate screening was provided or whether a person transferred was stable. The interpretive guidelines specifically state that the investigators are not to make decisions based on clinical information that was not available at the time of stabilizing or transfer. In addition, if an individual was misdiagnosed but the hospital utilized all of its resources, a violation of the screening requirement did not occur.

### B. MSE and Minors

A minor (child) can request an examination or treatment for an EMC. The hospital is required by law to conduct the examination if requested by an individual or on the individual's behalf to determine if an EMC exists. Hospital personnel should not delay the MSE by waiting for parental consent. If after screening the minor, it is determined than no EMC is present, the staff can wait for parental consent before proceeding with further examination and treatment. Hospitals are not relieved of their EMTALA obligation to screen, provide stabilizing treatment and/or an appropriate transfer to individuals because of prearranged community or state plans that have designated specific hospitals to care for selected individuals (e.g., Medicaid patients, psychiatric patients, pregnant women). Hospitals located in those states which have state/local laws that require particular patients such as psychiatric or indigent individuals to be evaluated and treated at designated facilities/hospitals may violate EMTALA if the hospital disregards the EMTALA requirements and does not conduct an MSE and provide stabilizing treatment or conduct an appropriate transfer prior to referring the individual to the state/local facility. If, after conducting the MSE and ruling out an EMC (or after stabilizing the EMC), the sending hospital needs to transfer an individual to another hospital for treatment, it may elect to transfer the individual to the hospital so designated by these state or local laws.

### C. MSE and Non-Emergency Services

If an individual presents to an ED and requests pharmaceutical services (medication) for a medical condition, the hospital generally would have an EMTALA obligation. If the individual requires the medication to resolve or provide stabilizing treatment of an EMC, then the hospital has an EMTALA obligation. Hospitals are not required by EMTALA to provide medication to individuals who do not have an EMC simply because the individual is unable to pay, does not wish to purchase the medication from a retail pharmacy, or did not plan appropriately to secure prescription refills.

If an individual presents to a dedicated emergency department and requests services that are not for a medical condition, such as preventive care services (immunizations, allergy shots, flu shots) or the gathering of evidence for criminal law cases (e.g., sexual assault, blood alcohol test), the hospital is not obligated to provide a MSE under EMTALA to this individual. However, attention to detail concerning blood alcohol testing in the ED is instrumental when determining if a MSE is to be conducted. If law enforcement personnel request that emergency department personnel draw blood from an individual brought to the ED for a blood alcohol test only and do not request examination or treatment for a medical condition such as intoxication, and if a prudent lay person observer would not believe that the individual needed such examination or treatment, then the EMTALA's screening requirement is not applicable to this situation because the only request made on behalf of the individual was for evidence. However, if for example, the individual in police custody was involved in a motor vehicle accident or may have sustained injury to him or herself and presents to the ED, a MSE would be warranted to determine if an EMC exists. When law enforcement officials request hospital emergency personnel to provide clearance for incarceration, the hospital has an EMTALA obligation to provide a MSE to determine if an EMC exists. If no EMC is present, the hospital has met its EMTALA obligation and no further actions are necessary for EMTALA compliance. Surveyors will evaluate each case on its own merit when determining a hospital's EMTALA obligation when law enforcement officials request screening or blood alcohol testing for use as evidence in criminal proceedings. This principle also applies to sexual assault cases.

## V. Stabilizing Treatments for Emergency Medical Conditions

If the hospital determines that the individual has an emergency medical condition, the hospital must provide stabilizing treatment within the *capability and capacity* of the hospital or provide appropriate transfer. *Capabilities of a medical facility* means that there is physical space, equipment, supplies, and specialized services that the hospital provides (e.g., surgery, psychiatry, obstetrics, intensive care, pediatrics, trauma care). *Capabilities of the staff of a facility* means the level of care that the personnel of the hospital can provide within the training and scope of their professional licenses. This includes coverage available through the hospital's on-call roster.

The *capacity* to render care is not reflected simply by the number of persons occupying a specialized unit, the number of staff on duty, or the amount of equipment on the hospital's premises. *Capacity* includes whatever a hospital customarily does to accommodate patients in excess of its occupancy limits. If a hospital has customarily accommodated patients in excess of its occupancy limits by whatever means (e.g., moving patients to other units, calling in additional staff, borrowing equipment from other facilities), it has, in fact, demonstrated the ability to provide services to patients in excess of its occupancy limits.

A hospital may appropriately transfer an individual before the sending hospital has used and exhausted all of its resources available if the individual requests the transfer to another hospital for his or her treatment and refuses treatment at the sending hospital.

In order to comply with the MSE and stabilization requirements of EMTALA, all individuals with similar medical conditions are to be treated consistently. Compliance with local, state, or regionally approved EMS transport of individuals with an emergency is usually deemed to indicate compliance. If community-wide plans exist for specific hospitals to treat certain EMCs (e.g., psychiatric, trauma, physical or sexual abuse), the hospital must meet its EMTALA obligations (screen, stabilize, and/or appropriately transfer) prior to transferring the individual to the community plan hospital. The patient must be screened and stabilized. Stabilized is defined as:

> "…that no material deterioration of the condition is likely, within reasonable medical probability, to result from, or occur during, the transfer of the individual from a facility...or that a woman has delivered the child and the placenta."

If a hospital is unable to stabilize an individual within its capability, an appropriate transfer should be implemented. To be considered stable, the emergency medical condition that caused the individual to seek care in the dedicated ED must be resolved, although the underlying medical condition may persist. After stabilizing the individual, the hospital no longer has an EMTALA obligation. The physician may discharge the individual home, admit him/her to the hospital, or transfer the individual to another hospital depending on his/her needs (the "appropriate transfer" requirement under EMTALA does not apply to this situation since the individual has been stabilized). For those individuals whose EMCs have been resolved, the physician or qualified medical person has several options:

- Discharge home with follow-up instructions. Hospitals are expected within reason to assist/provide discharged individuals the necessary information to secure the necessary follow-up care to prevent relapse or worsening of the medical condition upon release from the hospital; or
- Inpatient admission for continued care.

## VI. Inpatients

EMTALA does not apply to hospital inpatients. The existing hospital Conditions of Participation protects individuals who are already patients of a hospital and who experience an EMC. Hospitals that fail to provide treatment to these patients may be subject to further enforcement actions. If the surveyor discovers during the investigation that a hospital did not admit an individual in good faith with the intention of providing treatment (i.e., the hospital used the inpatient admission as a means to avoid EMTALA requirements), then the hospital is considered liable under EMTALA and actions may be pursued.

## VII. Conclusion

CMS wants consistent application of its investigation process and impositions of sanctions. They have allowed the public access to their investigator's guidelines. Hospitals should use this information to take appropriate corrective action now, before an investigation or complaint occurs. The next TSG Newsletter will detail regulations pertaining to *transfers* under EMTALA.

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Daniel Sullivan, MD, JD, FACEP will lecture on
Patient Safety and Risk Reduction and Advanced EMTALA

Monday, Oct. 18, 2004
10:30 AM – 11:30 AM
Emergency Medicine: Patient Safety and Risk Reduction

Tuesday, Oct. 19, 2004
1:45 PM – 3:15 PM
Advanced EMTALA: Learn It The Easy Way

# EMTALA Case Reporter
# Marrero v. Hospital Hermanos Melendez

253 F. Supp. 2d 179; Decided March 20, 2003

## Overview

This legal opinion is the result of the defendant hospital's motion to dismiss this EMTALA action alleging that there was no basis for the claim. This is called a motion for summary judgment.

A 63-year-old man woke up dizzy, vomiting, and with a severe headache. Because of his history of diabetes, hypertension and asthma, his wife took him to the closest emergency department. After waiting 2 hours to be seen by a doctor, he was given Tylenol, and the physician performed a brief physical examination and ordered a complete blood count (CBC). Five hours later, the physician saw the patient again. Some time later, the physician ordered a second CBC. The patient was released from the hospital without any further testing or management. The patient died soon after from cerebral edema secondary to a stroke.

The court said there were enough facts that a jury could find that no screening or inadequate screening was performed on the patient while in the ED. Therefore it dismissed the motion and allowed the case to proceed before a jury.

## Facts of the Case

**Christmas morning 2000**, Mr. Marrero, 63 years old, awoke feeling dizzy with a headache; he was vomiting, and was sweating and pale. Mr. Marrero had a history of diabetes mellitus, hypertension, asthma and psychiatric conditions. His wife took him to the Diagnostics and Treatment Center who sent him to the Hospital ED.

**Around 10:10a.m.,** the Marreros arrived at the hospital. Mr. Marrero was put in a wheelchair and taken to the waiting room. Mrs. Marrero gave the triage nurse the referral from the Diagnostics and Treatment Center, which stated the referral was due to high blood pressure.

**35 to 45 min. later**, Mr. Marrero bent forward in his wheelchair, almost fainting; he was rushed into the ED. At this time he was triaged and his vital signs were taken. He was categorized as "green" - having an illness but being stable.

**Approximately 12:25**, Dr. L. examined Mr. Marrero. Mr. Marrero told Dr. L. of pain in his head and chest. He was given Tylenol. The sworn testimony of the family and physician was that the physician did a brief evaluation, which did not include a neurologic evaluation or a funduscopic examination. No tests were ordered at this time for his head and chest pains. Approximately one hour later, the physician ordered a CBC and an electrocardiogram (ECG).

**At 1:41 p.m.**, blood was drawn for the CBC. Another CBC was ordered for 6 p.m. Blood was not drawn at 6 p.m. for the second CBC. The ECG was never performed.

**Over the next 5 hours**, Mr. Marrero was left unattended.

**7:00 p.m.,** Dr. M. again ordered a CBC, but did no additional physical exam.

**10:00 p.m**., Mr. Marrero's headaches got worse and he tied a cloth around his head to try to control pain.

**11:00 p.m.,** Dr. M. discharged Mr. Marrero. The physician testified that based upon the CBC results, the patient probably had a viral syndrome. The Marreros did not want to leave because Mr. Marrero was still experiencing severe headache pain.

**At midnight**, Mr. Marrero was discharged.

**A few days later**, Mr. Marrero died due to cerebral edema related to a cerebrovascular accident and arterial hypertension.

## The Court's Decision

The Court noted that Mr. Marrero waited almost 2 hours to be seen by a doctor after arriving at the ED with severe headaches, vomiting, a high blood pressure, and other conditions. The Court said that this was an unjustifiable delay and could be deemed a defective screening under EMTALA. The Court would not commit that the 2 hours was inappropriate, but referred that issue to the jury. The Court noted that based upon the medical record and expert testimony, it is possible that Mr. Marrero may not have been screened at all. He presented with symptoms which were clearly consistent with the presence of an emergency medical condition. An expert testified that anyone presenting to the ED with headache, nausea, vomiting, and weakness must receive a neurologic exam as part of the screening evaluation. The physician must consider possible cerebral pathology and perform a neurologic examination.

The Court was highly critical of the fact that the patient waited two hours for a triage evaluation, did not have a neurologic evaluation, was given Tylenol, and then waited another 5 hours before re-evaluation. The court felt there was enough information for a jury to decide that Mr. Marrero was not screened at all, or if he was, it was deficient.

## Discussion

The defendant hospital moved to dismiss the case alleging that the patient's family failed to state a claim under EMTALA. Following this type of motion for summary judgment, the Court must look at the case taking the facts in a light most favorable to the nonmoving party, in this case the patient's family. The Court can only dismiss a case when there is no reasonable basis for the claim as a matter of law. If there is any potential basis for the claim, the Court must let the case go to the jury. In this case, it appeared that the patient may not have been appropriately screened; therefore the Court dismissed the motion.

The two key issues here are the delay in triage and the failure to perform a neurologic examination. Several federal courts have found that inappropriate delays at triage may represent denial of a medical screening examination. The more important issue in this case is the physician's failure to perform a neurologic examination. **The medical screening examination is the process required to reach with reasonable clinical confidence, the point at which it can be determined whether a medical emergency does or does not exist.** A neurologic examination would certainly be required in this case in order to determine whether an emergency medical condition existed. Without this exam, the physician's physical examination would be considered deficient to establish the fact that an adequate screening examination had occurred, although that is ultimately an issue for the jury.

As previously mentioned, depending on the individual's presenting symptoms, the MSE represents a spectrum ranging from a simple process involving only a brief history and physical examination to a complex process that also involves performing ancillary studies and procedures such as (but not limited to) lumbar punctures, clinical laboratory tests, CT scans, and/or diagnostic tests and procedures. Thus, in this case, the physician may have had to go well beyond the neurologic examination to provide a MSE. For example, a CT scan may have been required.

Recently, there have been fewer cases filed based on allegations of a failure to provide medical screening examinations relative to the mid 1990s. For the most part, hospitals and emergency physicians are very familiar with EMTALA and understand the basic requirements of the medical screening examination and the need for stabilizing treatment. Emergency physicians should remain current with this federal law and its ever-changing supporting regulations and interpretive guidelines.

**Visit The Sullivan Group at the American College of Emergency Physicians *Scientific Assembly* in San Francisco**

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9 AM – 9:50 AM
Documentation: The Good, the Bad and the Ugly

11 AM – 11:50 AM
Misdiagnosis of the Dyspneic Patient

12 PM – 12:50 PM
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