THE SULLIVAN GROUP

TSG Quarterly Report

At the crossroads of law and medicine

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Editor's Note: We usually start the TSG Quarterly with a clinical adverse outcome or medical malpractice lawsuit. However, the big news this quarter is the publication of the final EMTALA regulations. Therefore, we start off this newsletter with a summary of the changes presented in the new regulations. For a complete review of EMTALA with the new regulations TSG offers "EMTALA Fundamentals" and an "EMTALA Comprehensive" web-based continuing education courses available at www.thesullivangroup.com.

One other quick item. Recently I was challenged by the state of Illinois to demonstrate my CME hours over a three-year period as a condition for re-licensing in Illinois. It took me several days to find and organize my CME credit from a number of hospitals. It was frustrating. I need a Continuing Education Credit manager and I thought you might too. Our Information Technology gurus have put together a Continuing Education manager on the TSG website. It is completely confidential and yours to use free of charge. It contains everything you need to monitor your CME or CE credits including the number of credit hours needed in each state. There is even a section that reminds you where you filed your CME / CE certificates. I hope you find it useful. If you have any suggestions to make it more user friendly, let us know.

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EMTALA Update
Summary of Final Changes to the EMTALA Regulations

Medicare Announce Final EMTALA Rules

On Friday August 29, 2003, the Centers for Medicare & Medicaid Services (CMS) issued a final rule clarifying hospital obligations to patients who request treatment for emergency medical conditions under the Emergency Medical Treatment and Active Labor Act (EMTALA). The new rule will take effect on November 10, 2003. For further information, the CMS publication provides a name and phone number: Thomas Gustafson at 410-786-4487. To view the entire CMS publication (it is over 250 pages double spaced), go to The Sullivan Group Home page (www.thesullivangroup.com) and click on EMTALA. You will see the hyperlink for the document on that page. If you are in charge of compliance at your hospital, TSG strongly recommends reading the entire document.

I. Clarification of "Comes to the Emergency Department"

The final rule seeks to clarify exactly when a patient is deemed to have "come to the emergency department," thus triggering a hospital's EMTALA obligations. CMS points out that questions arise when a patient does not present to the hospital's emergency department, but elsewhere on hospital property. The rule would create an EMTALA obligation in one of two ways:

1. The individual can present at a hospital's "dedicated emergency department" and request examination or treatment for a medical condition. Or,

2. The individual can present elsewhere on hospital property in an attempt to gain access to the hospital for emergency care (that is, at a location that is on hospital property, but is not part of a dedicated

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emergency department), and request examination or treatment for what may be an emergency medical condition.

CMS wants to further clarify that "comes to the emergency department" would also encompass other departments of hospitals, such as the labor and delivery department and psychiatric units of hospitals, that provide emergency or labor and delivery services to individuals who present as unscheduled ambulatory patients. "These departments will be subject to EMTALA requirements applicable to dedicated emergency departments, including requirements related to maintenance of an emergency department log and on-call requirements."

Patients may be transported between a hospital's dedicated emergency departments. This falls under the general category of 'doing the right thing.' For example, if a male patient presents to labor and delivery with abdominal pain, he should be transported to the most appropriate location for screening and stabilization.

"Comes to the Emergency Department" Exclusions

Under the September 2003 final rule, the following patients have not "come to the emergency department" and EMTALA would not apply:

1. Individuals who present for outpatient therapy or those who have begun to receive outpatient services as part of an encounter, e.g., patients presenting for an outpatient radiologic procedure or those presenting for physical therapy. Even if such a patient were to develop chest pain and be transported to the emergency department, EMTALA would not apply. The final rules contain an educational example: EMTALA is not triggered by a request for physical therapy (i.e., for a medical condition) at the hospital's on-campus physical therapy department. However, EMTALA would be triggered by that same request inside a hospital's dedicated emergency department.

2. Patients who present to a provider-based, off-campus department that is not a dedicated emergency department (e.g., off-campus physical therapy center, diagnostic radiology center, physician's office) with emergency conditions.

3. Those individuals on hospital property that the hospital had no notice of. The hospital must be on notice in order for any violation of the statute to take place.

II. Clarification of "A Request is Made for Examination or Treatment"

The new rule adopts a prudent layperson standard with regard to whether a request has been made for examination or treatment. This is obvious when an individual requests care. The issue arises when there has been no overt request for medical care.

Outside of the dedicated emergency department, such a request would be considered to exist if a prudent layperson observer would believe, based on the individual's appearance or behavior, that the individual needs examination or treatment for an emergency medical condition.

Inside the dedicated emergency department, such a request would be considered to exist if a prudent layperson observer would believe, based on the individual's appearance or behavior, that the individual needs examination or treatment for a medical condition.

III. The Dedicated Emergency Department

The 'dedicated emergency department' concept is one of the most important changes in the final rules. The term "**dedicated emergency department**" is new to EMTALA. "Dedicated Emergency Department" means any department or facility of the hospital, regardless of whether it is located on or off the main hospital campus, that meets at least one of the following requirements:

1. It is licensed by the state in which it is located as an emergency room or emergency department.

2. It is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment.

3. During the calendar year immediately preceding the calendar year in which a determination under section 489.24 is being made, based on a representative sample of patient visits that occurred during that calendar year, it provided at least one-third of all its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment.

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This new definition is helpful, but it creates additional hospital EMTALA burdens. The concept of a "dedicated emergency department" clarifies the scope of hospital EMTALA obligations, and it is very important as CMS **pulls back** from the prior broad-based coverage of all off-campus and outpatient departments. It appears that most urgent care units would fall within the definition of a dedicated emergency department, but this new definition obviously excludes other outpatient facilities, doctors offices, physical therapy departments, free-standing diagnostic centers, etc. Those hospitals that have developed EMTALA policy and procedure for multiple off-campus facilities may now disregard the EMTALA requirements if the facility does not fit the definition of a dedicated emergency department.

The third definition of "dedicated emergency department" is particularly troublesome. The retrospective measurement of patients with emergency medical conditions will be very subjective. This definition will inevitably cause confusion, and many hospitals will have difficulty determining whether certain centers meet the definition and whether EMTALA applies.

Assume that the definition applies to urgent care centers working under the hospital's Medicare provider number. Patients presenting to urgent care centers must receive screening and stabilization within the capability of the center. If the patient requires screening or stabilization services beyond the capability of the center, additional screening and stabilization services should be provided at the hospital that owns the center. Movement of the patient from the urgent care to the hospital is a transport, not a transfer, and EMTALA transfer documentation is not required.

If the patient requires emergency services from a closer facility, the patient can be transferred to that facility. In that case, EMTALA transfer documentation is required.

Recommendations:

1. Evaluate your hospital system. Determine which departments meet the criteria for "dedicated emergency department."

2. Be conservative in application of the third criteria. Use the EMTALA definition of emergency medical condition in your analysis.

IV. Definition of Hospital Property

For the purpose of determining when the EMTALA obligations are triggered for an individual who is on the hospital campus, "hospital property" will continue to be defined by the 250-yard test for describing the hospital campus (including parking lots, sidewalks and driveways) under the provider-based rules. However, "hospital property" does not include physician offices, rural health clinics, skilled nursing facilities, other entities that participate in Medicare separately from the hospital, and businesses such as restaurants, shops, and other non-medical activities.

V. The Hospital-Owned Ambulance

The early EMTALA regulations indicate that "hospital property" included a hospital-owned ambulance. That is, once the hospital ambulance arrived at a patient's house and the patient entered the ambulance, that patient had come to the hospital, thus invoking the hospital EMTALA obligations to screen and stabilize. This EMTALA provision has created problems in that it contradicts many community EMS transport protocols.

The September 2003 final rule clarifies that if a hospital-owned ambulance participates in community-wide EMS protocols that require the ambulance to transport patients to the nearest hospital, EMTALA would not apply. Thus, the hospital-owned ambulance can comply with local EMS transport protocols without violating EMTALA. The rule also states that this applies to air ambulance transport.

The September 2003 final rule states that if a non-hospital-owned ambulance is on the way to the hospital and makes radio contact, this is not a patient who has come to the emergency department under EMTALA. However, once the ambulance has arrived on hospital property, that is a patient who has come to the emergency department.

The ninth federal circuit in Arrington v. Wong recently ruled that radio contact by ambulance **did** establish an EMTALA obligation. At this time, this is only relevant in the ninth circuit (Hawaii, California, Alaska, etc.). The new final rule should provide guidance to the federal courts. The courts are bound by law and regulation. The Arrington decision is not consistent with the current CMS position. Hopefully the CMS position will put an end to the 'radio contact' issue.

VI. Individuals Presenting for Nonemergency Services

CMS is obviously responding to concerns that EMTALA has created a safety net for medical care in America's emergency departments, resulting in overcrowding and inappropriate use of emergency departments. The final rules provide several examples of the types of patients that would not have an emergency medical condition, and suggest that a less rigorous screening process may be appropriate.

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The final rules with public comments indicate that CMS appears to be scaling back on the hospital's obligations regarding screening. CMS states, "We expect that in most cases in which a request is made for medical care that clearly is unlikely to involve an emergency medical condition, an individual's statement that he or she is not seeking emergency care, together with brief questioning by qualified medical personnel, would be sufficient to establish that there is no emergency condition and that the hospital's EMTALA obligation would thereby be satisfied."

This is the first instance in which CMS indicates that a qualified medical person, a screener if you will, could ask a few brief questions and establish that there is no EMTALA obligation. This seems to suggest that with some training, triage personnel could become qualified medical personnel for the purpose of determining whether there is an emergency condition. To date, this decision is overwhelmingly made by the emergency physician who screens the patient only after the patient has gone through the entire gamut of triage, has been assessed by the primary nurse, and has been moved into a stretcher space. Asking a "few brief questions" is certainly a departure from our current understanding of the screening process.

In response to a public comment, CMS states in the final rules that "Once the individual is screened and it is determined the individual has only presented to the dedicated emergency department for a nonemergency purpose, such as followup care, the hospital's EMTALA obligation ends for that individual at the completion of the medical screening examination."

One public comment suggested that nurses or other qualified medical professionals be allowed to provide screening exams. The CMS response was, "… we believe the individual could be screened by the appropriate non-physician emergency department staff and, if no emergency medical condition is found to exist, referred to his or her physician's office for further treatment…We note that while EMTALA does not require that all screenings be performed by an M.D. or D.O., any non-physician (such as an emergency room registered nurse) who performs such screening should be an individual whom the hospital has designated as a 'qualified medical person'…."

This is interesting, but be careful if you intend on implementing any changes in your screening process. These final rules with comments don't change the law or regulations. EMTALA never required physician screening; nor did EMTALA require any further care or treatment once the 'screener' determined that there was no emergency medical condition. So what exactly have we gained through these final rules?

One comment suggested that CMS should clarify that EMTALA medical screening is not required for individuals who request a medical service that is not examination or treatment for a medical condition, such as preventive care services, pharmaceutical services or medical clearances for law enforcement purposes (such as blood alcohol tests required by police). CMS agrees.

CMS responded that a hospital has no obligation under EMTALA to an individual who comes to a dedicated emergency department if there is no request made by or on behalf of the individual for examination or treatment for a medical condition, and the individual's appearance or behavior would not cause a prudent layperson observer to believe that examination or treatment for a medical condition is needed and that the individual would request that examination or treatment if he or she were able to do so. This is not a gain; this is consistent with prior EMTALA law.

CMS would not agree that a hospital has no obligation under EMTALA to an individual who presents at a dedicated emergency department for "nonemergency purposes," because such a purpose can be a medical one and the statute requires that a hospital perform a medical screening examination to any individual who presents to the emergency department with a medical condition. CMS explicitly agrees that if the individual presents for services that are not examination or treatment for a medical condition, such as preventive care services, there is no screening requirement.

One commenter asked for clarification about screening and vital signs. CMS states, "We do not believe the taking of a patient's vital signs is required for every presentment to a hospital's dedicated emergency department." CMS also states that in most cases in which 1) it appears unlikely that a patient has an emergency medical condition, and 2) an individual states that he or she is not seeking emergency care, then brief questioning by a qualified medical person (screener) would be sufficient to determine that there is no EMC and thus no EMTALA obligation.

CMS specifically points out that requests by law enforcement authorities for medical clearance of persons who are about to be incarcerated or for blood alcohol or other tests will be evaluated on a case by case basis. They would not commit to the fact that these patients are not covered by EMTALA.

CMS addressed the situation where after hours, all individuals present to registration through the emergency department. CMS points out that EMTALA does not apply "to individuals who may pass through a hospital's emergency department but do not request examination or treatment for a medical condition…."

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In general, these words from CMS seem more like interpretive guidelines than a substantive regulatory change. They will provide CMS and state regulatory personnel with guidance when reviewing alleged claims against hospitals and when performing on-site evaluations. They do not appear to create new law.

Another caveat: CMS once again points out in this final rule that triage is not equivalent to a medical screening examination. Triaging merely determines the "order" in which patients will be seen, not the presence or absence of an emergency medical condition. If you intend on changing your screening process, make sure to go through a formal program and provide your personnel with additional training to make them 'qualified medical providers' for the purpose of providing screening examinations. Then watch your program carefully!

VII. On-Call Requirements

The current emergency department on-call situation in the United States is inadequate. In 1986 when EMTALA was first passed, it positively influenced the patient dumping problem. One of the main reasons that it worked was because the stabilizing requirement included subspecialty care from the emergency department on-call schedule. At that time, the on-call schedule included orthopedic physicians, neurosurgeons, plastic surgeons, ophthalmologists, etc. In the last several years, subspecialty physicians have been exiting the on-call list for a number of reasons, including exposure to EMTALA liability, increasing costs of malpractice insurance, and the worsening financial and time burdens of being on-call.

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

The new CMS final rules are going to worsen the on-call situation. Some hospitals will continue to require on-call participation as a prerequisite of medical staff membership. However, in those hospitals without such a requirement, the new rules will result in a dramatic thinning of on-call schedules around the country. This will result in the need to transfer increasing numbers of patients for specialty care to those hospitals that maintain a full on-call roster. Therefore, much of the original success in stopping the dumping problem will be lost. There were many public comments regarding this CMS position. However, CMS seems set in its position.

This is interesting because the original regulations and the interpretive guidelines contain a provision whereby the hospital must maintain an on-call schedule that is representative of the services the hospital provides to the community. Thus, if the hospital provides neurosurgical services to the community, there is a basis in the original regulations to demand neurosurgery on the on-call schedule. However, CMS is clearly not taking that position.

This CMS interpretation has already had dramatic effects in the provision of emergency services around the country. Finding a specialist on an on-call schedule is becoming increasingly difficult. As a result, a patient with serious intracranial pathology may wait in an emergency department for hours while the emergency physician scrambles to find a hospital that will provide life-saving services.

There will be some level of scrutiny of the on-call schedule by CMS. CMS states that it will consider all relevant factors, including the number of physicians on staff, other demands of the physicians, the frequency with which the hospital's patients typically require on-call services, and the provisions the hospital has made for situations in which a physician in the specialty is not available or the on-call physician is unable to respond. The proposed rule also states that a hospital must have policies and procedures for when a particular specialist is not available or unable to respond for reasons beyond his or her control.

Time will tell what ultimate affect this will have on America's emergency departments. The Sullivan Group is not optimistic.

Emergency and On-Call Physician Disagreement

There is often a constructive tension between the emergency physician and the on-call specialist. Usually the collective wisdom wins the day. However, the reality is that there may be disagreement between the emergency physician and the on-call physician regarding the need for additional screening evaluation, stabilizing treatment, or transfer.

The September 2003 rules are very clear on the requirements when there is disagreement. "While the emergency physician and the on-call specialist may need to discuss the best way to meet the individual's medical needs, we also believe any disagreement between the two

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regarding the need for an on-call physician to come to the hospital and examine the individual must be resolved by deferring to the medical judgment of the emergency physician or other practitioner who has personally examined the individual and is currently treating the individual."

VIII. Referral Agreements

Most emergency department on-call lists do not contain all physician sub-specialties. Prior EMTALA documents suggested that hospitals should or must have referral agreements with other hospitals for subspecialty areas not covered by the on-call list. However, the September 2003 final rule indicates that CMS agrees "that it is appropriate for hospitals to have referral agreements with other hospitals to facilitate appropriate transfers of patients who require specialty physician care that is not available within a reasonable period of time at the hospital to which the patient is first presented. However, we are not mandating the maintenance of such agreements in this final rule."

IX. Prior Authorization

According to the EMTALA statute, participating hospitals are not to delay the provision of a medical screening examination, treatment, or both, to inquire about the individual's method of payment or insurance status. In the original regulation's comment section, CMS stated that hospitals may continue to follow reasonable registration processes for emergency room individuals, including requesting information about insurance, as long as these procedures do not impede provision of necessary treatment and as long as all individuals to whom the procedures apply be treated similarly. A hospital should not delay treatment to any individual while it verifies information provided.

In November 1999, CMS and the Office of the Inspector General (OIG) issued a "Special Advisory Bulletin" indicating that hospitals should not seek payor authorization from managed care organizations until after the hospital has provided the required medical screening examination and has initiated necessary stabilizing treatment.

As a result of these multiple CMS documents and related regulatory actions against hospitals, emergency departments have largely moved to bedside registration. The financial interview is withheld until the physician has finished screening. This new method of obtaining financial information has largely removed any possible delay for the purpose of screening, but has significantly complicated the emergency department throughput process.

The final rules address these issues:

1. **Prior Authorization.** Prohibit a hospital from seeking prior authorization (or directing any other individual to seek prior authorization) for screening or stabilization services until after the hospital has provided the medical screening and initiated further examination and treatment that may be required to stabilize the emergency medical condition.

2. **Consultation.** Clarify that the prior authorization prohibition does not preclude the treating physician (or other qualified medical personnel) from seeking advice on the patient's medical history and needs, so long as the consultation does not inappropriately delay required emergency services.

3. **Patient Registration.** Allow hospitals to follow reasonable registration processes for emergency patients, including asking for insurance status and information so long as the inquiry does not delay the medical screening or treatment. Reasonable registration processes may not "unduly discourage individuals from remaining for further evaluation."

X. Does EMTALA Apply to Admitted Patients?

No! In another surprising move by CMS, once a patient is admitted to the hospital, the hospital EMTALA obligation ends. EMTALA does not apply to inpatients. This is a surprising but welcome change in the September 2003 final rule. There has been confusion over EMTALA and inpatients for years. The Galen case that went all the way to the United States Supreme Court involved a patient who had been an inpatient for weeks.

The CMS analysis leading to this conclusion is interesting. The basis for the change lies in an analysis of federal court interpretation of this issue. Several courts have concluded that a hospital's obligations under EMTALA end at the time of admission (e.g., Bryan v. Rectors and Visitors of the University of Virginia, 95 F.3d 349 (4th Cir. 1996); Bryant v. Adventist Health Systems/West; 289 F.3d 1162 (9th Cir. 2002)).

In reaching this result, the courts focused on the definition of "to stabilize" from the EMTALA statute. The courts found that stabilizing treatment must be provided in a way that avoids material deterioration of an individual's medical condition if the individual is being transferred from the facility. Admitted patients are neither transferred nor discharged; thus the hospital would not have an obligation

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to stabilize under EMTALA. CMS agreed, and EMTALA no longer applies to inpatients.

One caveat: If inpatient status is used to avoid EMTALA obligations, the hospital will be found in violation. Also, one wise emergency physician provided a public comment that EMTALA should not apply to those emergency department patients who are admitted but must be held in the department because there are no inpatient beds. CMS agrees and defines inpatient. An inpatient is "a person who has been admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services. Generally a person is considered an inpatient if formally admitted as an inpatient with the expectation that he or she will remain at least overnight and occupy a bed even though it later develops the he or she can be discharged or transferred to another hospital and does not actually use a hospital bed overnight." Therefore, patients on hold in the department would typically be considered inpatients, and EMTALA is no longer applicable.

XI. Responding to Emergencies Outside the Emergency Department

For patients presenting with a potential emergency on hospital property but outside of the emergency department, it is not required that an emergency department physician leave to respond and provide treatment to an individual.

EMTALA requires that the hospital must provide treatment within its capabilities. Either the hospital has the capability to respond or must provide alternate means of treating such an individual, such as a transfer.

In general, the ED should attempt to send personnel to the site for the purpose of transport back to the ED. If that is impossible, then a call to 911 is appropriate for transfer under the new regulations.

XII. Application of EMTALA in National Emergencies.

In the final rules, CMS adopted a new regulation that the sanctions under EMTALA for inappropriate transfers during a national emergency (such as a bio-terrorist attack) do not apply to a hospital with a dedicated emergency department located in an emergency area.

Conclusion

CMS is very impressed with this new round of regulations. The following is a quote from the CMS website: "The revisions provide clear, common sense rules for responding to people who come to a hospital for treatment of an emergency condition. They are designed to ensure that people will receive appropriate screening and emergency treatment, regardless of their ability to pay, while removing barriers to the efficient operation of hospital emergency departments."

CMS may be overstating the clarity of the new provisions a bit. Some of the changes and clarifications are very welcome, but many of the changes simply restate pre-existing law and regulation.

The exclusion of on- and off- campus facilities that are not 'dedicated emergency departments' is a dramatic and positive change. The CMS position regarding on-call physicians is problematic and will have a negative impact on patient care in this country.

For those of you interested in more information on EMTALA, The Sullivan Group offers a web-based "Fundamental" and "Comprehensive" EMTALA course including all the relevant new regulations. Both courses provide CME and CE credits. For more information on the courses, contact us at info.thesullivangroup.com.

Emergency Medicine Malpractice Case Reporter

Patient Presentation and Primary Nurse Evaluation

A 35-year-old woman presented to the emergency department at 2235. This patient arrived by ambulance and was brought directly into a stretcher space. The primary nurse evaluation revealed the following initial vital signs: temperature 96; pulse 130; respiratory rate 40; and blood pressure 100/51.

The nurse noted "Chief Complaint of possible syncope. Airway: Breath sounds clear. Breathing: Rapid respirations. Right leg and left hand in cast. Placed on cart # 3 per Metro Fire Department. Alert, answers all questions. Placed on cardiac monitor. Pulse Ox 97%. Denies allergy or medications. Fell and bumped head on concrete."

Physician Evaluation

The physician examined the patient at 2245. In his history he noted that the patient is a 35-year-old female with a history of passing out while coming from a funeral, hitting her head with a questionable loss of consciousness.

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Arrived in ER diaphoretic, tachycardic in acute distress, talking and screaming. Confused.

On physical exam he noted: HEENT Normal; Neck Supple; Lungs Clear, equal breath sounds; Heart tachycardic. S1 S2 normal without murmurs; Abdomen soft, Grossly obese. Bowel sounds normoactive. No guarding or rebound; Extremities without edema or cyanosis. Cast on left wrist and right ankle.

The physician's initial impression was "head trauma." He ordered a CT of the head, a CBC, Chemistry Profile, PT and PTT, cardiac markers and a chest X-ray.

Nursing Progress Notes

The primary nurse noted the following in her progress notes:

2250 - IV started. Extremely wild. Swinging arms. Uncooperative. Responds to verbal stimuli. Grossly obese. BP 100/60. Pulse 138. Resp. 40.

2300 - Valium 10mg IVP. Four-point leather restraints placed.

2306 - Versed 2.5 mg IVP. Dr. Smith preparing to intubate.

2308 - Tube placed per Dr. Smith without complication. Placed on ventilator.

2339 - Patient transported to radiology for head CT. BP 98/60 Pulse 140.

0025 - Return from CT

Diagnostics

The PT and PTT within normal limits. The CBC revealed a white blood cell count of 18,000 with no left shift. The chemistry profile revealed a glucose of 385, BUN 12, Creatinine 1.5, Sodium 142, Chloride 105, and a Bicarb or 16.4. Cardiac markers were completely within normal limits. The chest X-ray was normal. No infiltrates. The CT of the head was normal. There was no bleed and no indication of trauma.

Resuscitation Progress Notes

After the patient returned from CT, her condition continued to deteriorate.

The continuing nursing progress notes reveal the following:

0030 - BP 80/60. Pulse 146. Placed in Trendelenburg.

0100 - Arterial blood gas drawn. Patient struggling on endotracheal tube.

0116 - CPR started. See code sheet.

0148 - Code called. Stopped CPR.

Physician Progress Note Post Code

Following the code, the physician wrote the following note.

"This patient had a history of being upset after leaving her father's funeral and passing out and had head trauma secondary to passing out. I ordered a CT scan of the head after intubation and establishing an IV site. CT scan was negative. CBC and blood gas reports returned suggesting metabolic acidosis. Patient had no urine output during this period, hence septic shock was the next impression, however during the administration of sodium bicarbonate the patient coded and expired. Cause of death, possible cardiopulmonary arrest secondary to septic shock."

Medical Examiner's Report

Cause of death, massive saddle embolus in the pulmonary arteries and multiple emboli throughout both lungs. Source of the emboli, deep vein thrombosis in the right leg. Probably deep vein thrombosis (DVT) secondary to cast immobilization of the right leg, leading to massive pulmonary thromboembolism.

Case Outcome

The physician was sued for the failure to administer a thrombolytic agent in a timely manner. The case went to trial. The defense felt that it was possible that there may have been a breach in a standard of care in failure to administer a lytic agent, but that this patient would have died with or without a thrombolytic agent. Thus there was no legal 'causation.'

The jury determined that there was a breach in a standard of care for the failure to administer a lytic agent and that the breach caused this patient's death. The jury rendered a verdict against the emergency physician for over two million dollars.

Case Discussion

1. Bad Decision. This jury made a bad decision. They should have determined that there was no legal causation. Even if they determined that there was a breach in a standard of care, there seems little likelihood that this patient would have lived. In order to find for the plaintiff,

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the jury must find that there was a breach in a standard of care that caused injury. The major issue in this case was causation. The jury decided that based on the facts of the case, the breach caused the injury. Unfortunately, the defense may not appeal a case on an issue of fact, only on an issue of law. Based on the facts, the jury believed that a lytic agent may have saved this patient's life. The jury was probably wrong.

2. Was thrombolysis appropriate? This patient presented at 10:30 PM and arrested around 1:15 AM. In the interim, this physician had to manage a critically ill patient with multiple interventions. It is reasonable to suggest that most physicians in a busy emergency department would not have gotten around to a correct diagnosis and administration of a lytic agent in a timely fashion. The case is presented not to suggest that this physician breached a standard of care, but rather to demonstrate a case in which a physician could have considered pulmonary embolism in the differential diagnosis and the kind of pulmonary embolism case in which a lytic may be used.

To paraphrase from a popular emergency medicine text, immediate fibrinolytic therapy is recommended for patients with pulmonary thromboembolism (PTE) who are hypotensive, have massive PTE, have had syncope with persistent hemodynamic compromise, are significantly hypoxemic, or have other evidence of depleted cardiopulmonary reserves. This case clearly meets the criteria set out in most emergency medicine texts. In retrospect, the patient had a syncopal episode and had hemodynamic compromise related to the PTE. Had the physician arrived at the conclusion that this was a probable PTE, lytic therapy would have been appropriate. Note that the recommendation is for a "patient with a PTE." In this case, that was not clear until the autopsy.

3. Risk Factors. Should this physician have considered pulmonary thromboembolism? Possibly. The patient was obese, she had recent trauma, and had a cast on the right leg. She was clearly at risk for DVT and pulmonary embolism. The risk factors would include both immobilization and direct injury to endothelium from the original trauma. This physician first considered an intracranial event and then considered sepsis. Perhaps a broader differential would have been appropriate.

Conclusion

This is a recent jury verdict. This is a difficult case with a terrible result. The jury verdict was a shock to the physician and the entire defense team. Most medical malpractice cases that go to a jury are won by the defense. However, it is always a role of the dice. This case was heard in a particularly difficult jurisdiction.

There has been an increase in pulmonary embolism cases in recent years. This case demonstrates one of the typical allegations in 'failure to diagnose' pulmonary embolism cases. Thrombolytics are not in common use in PE cases. However, the clinician should be aware of the current indications for use of thrombolytics in proven or suspected PE cases. Carefully document the thought process behind administration.

Special Article: Good Samaritan Laws

According to the dictionary, a "Good Samaritan" is "one who compassionately renders personal assistance to the unfortunate." (Webster's *Third New International Dictionary*, 979, 1965.) There are two types of laws that citizens of the United States abide by: common law and statutory law. Common law is generally applicable to everyone, unless the state they reside or act in has authorized a statute on the topic.

Speaking strictly about an individual acting as a good samaritan, there is no common law duty to rescue a person who is in peril absent some relationship between the parties that creates a special responsibility not owed to the general public. Absent a Good Samaritan statue, if one voluntarily undertakes to rescue a stranger, the rescuer is liable for any physical harm that results from failure to exercise reasonable care.

Common law does not provide for any incentive to aid your fellow citizens, so State legislatures have enacted Good Samaritan laws with the goal in mind to provide an incentive for medical intervention in an emergency. Since 1959, all fifty states and the District of Columbia have enacted Good Samaritan laws. The statutes encourage physicians, and sometimes others, including laypersons, to render emergency care at the scene of an accident without fear of common law liability if they fail to exercise reasonable care when providing the emergency care.

The following list contains examples of the different ways states define Good Samaritan care.

California - emergency care at the scene of an emergency

Georgia - emergency care to a person who is a victim of an accident or emergency

Illinois - emergency care without fee to a person

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Kansas - emergency care or assistance at the scene of an emergency or accident

Montana - emergency care or assistance...at the scene of an emergency or accident

Nevada - emergency care or assistance in an emergency

Utah - any act or omissions [by the rescuer] while rendering or attempting to render assistance to an injured party.

As you read the following case examples, observe the usage of the words 'accident' and 'emergency.' The defining of these two words has been a stumbling block for the courts around the country for years. Black's *Law Dictionary* defines these terms:

1) An "accident" can be defined as a sudden, unexpected event.
2) An "emergency" can be described as an unexpected condition or set of circumstances requiring immediate attention.

Gordon v. Beckerman, 614 N.E.2d 610

Robert was awakened by his wife, Mary Ann; she complained of left chest pain, which radiated down her left arm, an upset stomach, and that she was very hot. Dr. B., a neighboring doctor who lived a few blocks away, was called rather than attempting to take Mary Ann to the hospital or call an ambulance. Dr. B. was not Mary Ann's usual physician, but was in practice with her family doctor. Dr. B., upon being told of Mary Ann's symptoms, agreed to come and see her.

Approximately ten minutes elapsed between the phone call and the doctor's arrival. Dr. B. examined Mary Ann in her bed and diagnosed her ailment as pleurisy of the left lower lung. He assured the Gordons that pleurisy was not serious, and prescribed pain and anti-nausea medication for Mary Ann. Dr. B gave Robert some samples of the medication he had in his bag. The Gordons were instructed to call Dr. B. again if Mary Ann's symptoms had not improved in an hour. Dr. B. made an appointment to see Mary Ann in his office at 9:00 that morning for further evaluation.

Approximately one hour after treatment, Mary Ann's condition did not improve; she began gasping for breath and choking. Robert called Dr. B., who returned within three to four minutes. When he arrived, Mary Ann was in full cardiac arrest, lying on the bed, not breathing, with dilated pupils and a blue face. Dr. B. initiated cardio-pulmonary resuscitation. Mary Ann was transported by ambulance to the nearest hospital. Resuscitation was initially successful, but she never regained consciousness, and subsequently died.

An autopsy disclosed that her initial symptoms were the result of an atherosclerotic heart disease, and that she had suffered a myocardial infarction.

Issue: Whether Dr. B. is entitled to immunity under the Good Samaritan Law.

Parties Contentions: Dr. B. claims he was rendering emergency care during an emergency and is therefore entitled to the protection of the Good Samaritan Law. Robert responds that the Good Samaritan Law applies only to persons who render emergency care at the scene of or to the victims of an accident, and as a result, Dr. B.'s conduct did not fall within the Law's scope.

Case Outcome: The Good Samaritan Law does not apply.

Reasoning of the Court: The current Good Samaritan Law in Indiana was enacted in 1971. Indiana's Good Samaritan Law applies to any person who, gratuitously and in good faith, renders emergency care: 1) at the scene of an accident, or 2) to the victim thereof. It is clear then that only persons who render emergency care at the scene of or to the victim of an accident are entitled to the Law's immunity.

Dr. B. first argues that the legislature intended the statute to apply not only to accidents, but to other emergencies as well. The court does not agree. The plain language of the act does not support Dr. B.'s claim.

Prior to the 1971 amendment, Indiana's Good Samaritan Law applied to emergency care rendered "at the scene of an accident, casualty, or disaster to a person injured therein...." Since the legislature altered the scope of the Law and did not expand its purview to include all emergencies as other states have, the court concluded that the legislature did not intend the Good Samaritan Law to apply to all emergencies.

The sticking point in analyzing Good Samaritan laws is the distinction between an "accident" and an "emergency." The Indiana court holds that an *accident is a single discrete event causing unexpected consequences*, while an *emergency is a condition that has unexpectedly arisen*. An "emergency" can be thought of as the effect of an "accident," but not all emergencies are the result of accidents, as the condition could develop from a gradual series of events, and all accidents do not necessarily create emergencies. The term "emergency" has a broader scope than the word "accident," and the terms are not synonymous. Therefore, as used in the Good Samaritan Law, the legislature must

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have intended "accident" to mean a type of sudden calamitous event, and not all situations that might require immediate action.

The undisputed facts established that Mary Ann's condition was not the result of a sudden calamitous event of the type contemplated by the legislature. While her symptoms constituted circumstances of so pressing a character that some action needed to be taken, she was not the victim of an "accident" as that term is used in the Good Samaritan Law.

Jackson v. Mercy Health Center, 1993 OK 155

At the Hospital's invitation Tim Jackson [the visitor] accompanied his pregnant wife to the operating room to comfort her and to observe his baby's delivery by Caesarean section. Mr. Jackson became dizzy while watching preparations for the surgical procedure. Hospital personnel came to his rescue by taking his arm and seating him upon his wife's hospital bed, which had been left in the hallway outside the surgery room. After being seated but not secured he fell and injured himself.

Issue: Whether the Good Samaritan Act, 76 O.S. 1991 § 5, gives defendant Mercy Health Center, Inc. [the Hospital] immunity from liability for an allegedly negligent attempt by its personnel to render medical aid to plaintiff Tim Jackson, a hospital visitor.

Case Outcome: The Good Samaritan Act does provide immunity.

Reasoning of the Court: There were two issues considered in this dispute: (a) whether the visitor had a prior contractual relationship with the Hospital, which would take him out of the Act's purview, and if not, (b) whether his dizziness created an emergency within the meaning of the Act.

The visitor in this case claims that he did not receive "emergency care" since he was not in obvious danger of serious bodily harm or death. The visitor urges that the childbirth class he attended and his agreement to pay his wife's hospital expenses with those of his child transformed his status vis-a-vis the Hospital from one of visitor to that of a hospital patient. According to the visitor, any contract he may have had with the Hospital, even if no hospital/patient relationship was created, took the medical provider out of the Act's scope and imposed upon it a duty to actively render care when he became dizzy in the operating room. The plaintiff hoped to succeed on a negligence action claiming that the hospital owed him a duty; they breached that duty, and therefore owed him damages.

The Oklahoma court disagreed with the plaintiff holding that the statutory immunity stands whenever a *stranger*, such as a visitor, whether an invitee, licensee, or trespasser, is assisted in an emergency. The plaintiff had agreed to pay for hospital services to be performed for his wife and child, but not for himself. The court then concluded that his status was that of a visitor. The record showed no relationship between the Hospital and the visitor - contractual, status-based, or otherwise - which would confer on the latter the status of a patient and make the statutory Good Samaritan immunity unavailable.

Oklahoma adopted the Good Samaritan Act, 76 O.S.1991 § 5, in 1963. It abrogates the common-law rescue doctrine for medical providers in an effort to encourage them to risk helping strangers in need of succor, even when they have no duty to render aid.

Good Samaritan immunity rests on three elements:

(1) the absence of a prior contractual relationship between the rescuer and the injured person,
(2) the characterization of the rescuer's act as having been done in good faith, voluntarily and without compensation and
(3) the injured person's apparent need of emergency medical aid. Rescue is not limited to any location; it can take place "wherever required."

Within the Act's intended meaning an emergency occurs whenever a stranger appears (or may be perceived) to be ill or in need of succor.

The visitor's dizziness occurred in the operating room; he was holding his wife's hand while she was being anesthetized for surgery. The testimony of a nurse who was an expert witness for the visitor, if taken as true, does not elevate the presence of emergency to a disputed fact issue. The medical provider need not have waited before rendering aid to see if the visitor would suffer total collapse. The Hospital was clearly within the Act's protection when its personnel escorted the visitor out of the surgery area, seated him on the bed in the hallway, and then redirected their attention to the wife.

Hernandez v. Lukefahr, 879 S.W.2d 137

Two-month-old Rey Hernandez, Jr. was brought to the emergency room of Bayshore Medical Hospital by his grandmother because he was having respiratory problems. She administered CPR to the infant before taking him to the hospital.

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Dr. L., a pediatrician, was on another floor of the hospital when a nurse informed him of the hospital's emergency call over the loudspeaker for a pediatrician to go immediately to the emergency room. Dr. L. responded to the call, and when he arrived at the emergency room, saw the emergency room physician performing CPR on an infant. Dr. L. joined the rescue efforts. After more than one hour of attempting to resuscitate the child, Dr. L. noted that the infant's pupils were fixed and dilated, and that the cardiac monitor showed no activity. Dr. L. pronounced the infant dead.

The family stayed with the infant while awaiting the arrival of the medical examiner, and during this time they noticed some movement by the infant. They informed a nearby nurse of the movement, but the nurse did not make any inquiry, stating that the movement had to have been induced by the medication given in the resuscitation efforts. However, a pulse was found on the infant approximately one and one-half hours later, and the infant was transported to Texas Children's Hospital. A few days later, the infant's cardiac and respiratory activity ceased completely.

Issue: Whether or not Defendant doctor was provided immunity under the Good Samaritan Laws of Texas.

Case Outcome: Dr. L. is granted immunity.

Reasoning of the Court: As of the date of the alleged malpractice the statute read as follows:

(a) A person who in good faith administers emergency care at the scene of an emergency or in a hospital is not liable in civil damages for an act performed during the emergency unless the act is willfully or wantonly negligent.

(b) This section does not apply to care administered:

(1) for or in expectation of remuneration;

(2) by a person who was at the scene of the emergency because he or a person he represents as an agent was soliciting business or seeking to perform a service for remuneration;

(3) by a person who regularly administers care in a hospital emergency room; or

(4) by an admitting physician or a treating physician associated by the admitting physician of the patient bringing a health-care liability claim.

The ***first*** exception in the statute applies to a person who administers the care "for or in expectation of remuneration." The testimony of Dr. L. shows that he did not receive any compensation for his services that day, nor did he render his services in expectation of compensation.

The ***second*** exception does not apply because Dr. L. was likewise not acting as an agent on behalf of any entity seeking or expecting remuneration for the services.

The ***third*** exception applies to "a person who regularly administers care in a hospital emergency room." Dr. L. established that he was not baby Rey's doctor, he had never before seen the infant or the infant's mother, and he was not one of the doctors who specializes in and or is routinely assigned to an emergency room, including the emergency room at Bayshore Medical Center.

The ***fourth*** exception in the statute applies to care administered "by an admitting physician or a treating physician associated by the admitting physician of the patient bringing a health-care liability claim." Although there is no admitting physician in the fact scenario before us, plaintiff argues that because Dr. L. "treated" the infant, he became a treating physician within the meaning of this fourth exception. This interpretation of the statute fails for two reasons: 1) To say that any physician who assists in an emergency automatically becomes a treating physician would obviously frustrate the purpose of the statute, that purpose being to encourage physicians, and anyone else, to render aid in an emergency without fear of potential liability. 2) The treating physician is referenced in the statute only with regard to the admitting physician. An admitting physician is a physician who admits a patient for care in the hospital, and in our facts, there is no such physician. The infant may later have been admitted to Texas Children's Hospital after the incidents at the emergency room of Bayshore Medical Center, but Dr. L.'s involvement does not rise to the level of admitting the infant into a hospital.

TSG Commentary: The Scope of Good Samaritan Legislation

The scope of Good Samaritan Legislation has expanded over the years. In some cases it has even moved into the hospital as demonstrated in the Hernandez case above. Remember that every state has a different statute, and that you cannot extrapolate the decisions above to care provided in your state. The scope of your Good Samaritan Law will be based upon precedent in your state, and the court's interpretation of the plain language of the statute.

How the Statute is used in Litigation

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First, a lawsuit is filed as in the cases reviewed above. The defendant responds to the claim by using the Good Samaritan Statute as an affirmative defense. An affirmative defense is a matter asserted by the defendant, which, assuming the complaint to be true, constitutes a defense to the complaint. It attacks the plaintiff's legal right to bring an action as opposed to attacking the truth of the claim.

This concept is often misunderstood by medical professionals. Good Samaritan does not prevent a lawsuit. Good Samaritan may stop a lawsuit once filed. Whether the statute applies to the facts of the case is determined by the Court. The Court will look to prior cases in that jurisdiction and look to the actual language of the statute in order to determine if it applies.

Immunity for Emergency Practitioners

In general, it is difficult for practicing emergency physicians to depend upon protection from Good Samaritan Legislation for **in-hospital** care. As you can see in the Hernandez case, Texas excludes emergency physicians from Good Samaritan protection. It seems reasonable to expect Good Samaritan protection in the event that an emergency physician leaves an emergency department and runs to labor and delivery to cover a crash delivery with no expectation of remuneration. However, don't depend on it. A contractual obligation to cover emergencies in the hospital will almost certainly negate the possibility of Good Samaritan protection. Remuneration related to this obligation makes this a certainty.

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Landmark Case Review UPDATE

Roberts v. Galen of Virginia, Inc., 325 F.3d 776 (6th Cir. Ky. 2003)

In the Fall 2002 edition, we presented Roberts v. Galen, 525 US 249. Ten years after the complaint was filed, another chapter has been added by the 6th Circuit Court of Appeals.

For a review of the Supreme Court decision click on www.thesullivangroup.com and follow the newsletter links.

Here is a brief review of the case:

- **August 30, 1993.** The complaint was filed in the Western District of Kentucky. The Defendant, Galen, won a grant of summary judgment by the district judge, who held that liability under EMTALA's stabilization requirement could not be established without a showing that the hospital was motivated by improper financial considerations.
- **April 9, 1997.** The Sixth Court of Appeals then affirmed that holding.
- **January 13, 1999.** The United States Supreme Court reversed per curiam and remanded the case back to the initial trial court for retrial with the instructions that EMTALA's stabilization provision did not require the plaintiff to show an improper motive on the part of the defendant.
- **April 27, 2000.** The United States District Court for the Western District of Kentucky at Louisville tried the case again according to the remand of the United States Supreme Court.
- **April 9, 2003.** The Sixth Circuit Court of Appeals ruled on four issues that occurred during the re-trial of the case.

The facts: The Plaintiff, Johnson, was in a traffic accident and sustained severe injuries. She was hospitalized for six weeks before being transferred to a long-term care facility. The transfer to the facility is the subject of the case.

New facts: These are additional pre-transfer facts that may have affected the decision to transfer Plaintiff. D. K., S. G., and K. M. were nurses at Humana and had monitored Johnson's condition in the 36 hours before the transfer.

They noted that Johnson had an elevated white blood-cell count and temperature, cloudy urine, and expiratory wheezes. The nurses also reported caring for Johnson's right lung, the upper portion of which had collapsed on July 22, 1992. The nurses recorded their observations on Johnson's charts. K. M., who was on duty when Johnson was actually transferred, explicitly noted that she had not only charted her observations, but had brought them to the attention of Dr. A-J, who was Johnson's physician and the physician in charge of the transfer.

Since Johnson had experienced multiple urinary tract infections due to her indwelling Foley catheter, Dr. A-J suspected that the elevated temperature and cloudy urine were symptomatic of another urinary tract infection. Dr. A-J took chest x-rays and performed a bronchoscopy, and a urine culture was obtained. The x-rays indicated that Johnson's partially collapsed lung was stable and improving. Preliminary reports on the urine culture suggested to Dr. A-J that it was a case of colonized bacteria, a routine problem with patients hospitalized for long periods of time. Dr. A-J also noted that many of Johnson's symptoms – such as her high white blood-cell count and elevated temperature – had existed since her arrival at Humana and were likely not probative of anything. Believing that Johnson likely had a urinary tract infection and was in no serious danger, Dr. A-J put her on Bactrium, an antibiotic, and continued with her transfer.

Reason for returning to court: Plaintiff appealed, claiming the district judge erred when instructing the jury that there was an actual knowledge of the emergency medical condition component to liability under EMTALA.

Holding: This court affirmed the actions of the trial judge, and the Defendant prevailed.

Reason for affirming the previous holding: The sixth circuit has long held that liability under section b of EMTALA requires actual knowledge of the emergency medical condition.

Section b of the EMTALA statute requires hospitals to provide appropriate medical screening examinations to those who have emergency medical conditions or who are in labor, or to transfer them only in accordance with section c.

Section c generally prohibits transfers without a written request and waiver by the patient, a signed physician certification, or a qualified medical person's certification after consultation with a physician.

Section b explicitly states that the duty to stabilize patients only arises when "the hospital determines that the individual has an emergency medical condition." 42 U.S.C. § 1395dd(b)(1). This court referred to their decision in Cleland v. Bronson Health Care Group, Inc. 917 F.2d 266, 268 (6th Cir. 1990), where they interpreted that sentence to require "***actual knowledge*** of the doctors on duty or those doctors that would have been provided to any paying patient." Every other circuit court to consider this question has also required ***actual knowledge*** of the emergency medical condition.

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