



Recognizing EMTALA cases (Emergency Medical Treatment and Active Labor Act)

Regulating emergency care can be dangerous to the hospital as well as the patient

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Recent stories about the closure of emergency rooms for problems in treating patients have made headlines in the newspapers. As recently as August, federal regulators announced they were pulling the plug on a county hospital, Martin Luther King Jr.-Harbor Hospital, because it failed two federal inspections. For those patients of means, they may seek help elsewhere, but King-Harbor, which served one of the poorest neighborhoods in Los Angeles County, handled about 50,000 emergency room patients last year. One female patient died in May after being ignored and untreated on the emergency room lobby for 45 minutes.

The existence of such problems can be life-threatening to those who are transported to emergency rooms for live-saving measures. Consider the following:

A middle-aged man presents alone to the emergency room of ABC Hospital. He appears intoxicated. He has alcohol on his breath and a flask of liquor in his jacket pocket. The man also appears confused, has slurred speech and is unsteady on his feet. He is belligerent and he has vomit all over himself. The staff can't find his identification and he won't give them his name. Nurses and staff are disgusted by him but register him, anyway, as a John Doe. They assess his vital signs which are stable, but don't examine him or bring his case to the attention of the emergency physician; they have other more important things to do. Instead,

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they call a cab to take him to a local shelter because they do not know where he lives.

In the cab, he loses consciousness and 911 is called. Paramedics bring him back to the emergency room and note that he has a large hematoma on his scalp with crepitis (a crunchy feeling) on palpation. The emergency physician notes this and arranges for a stat CT of the head which reveals a depressed skull fracture and a large subdural hematoma. While awaiting neurosurgical consultation and operative decompression of the intracranial bleed, he has a sudden cardiopulmonary arrest and cannot be resuscitated. He is pronounced dead. His blood alcohol level, delivered to the emergency physician after he expired, was .07 percent, and thus, below the legal limit for driving.

His family shows up a short time later and the staff learns that the decedent was vice-president of operations for XYZ Industries, a large multi-national company. They also learn from the police and witnesses that he matches the description of a man who had been assaulted several hours earlier.

His family later sues the hospital in federal court for violating EMTALA (Emergency Medical Treatment and Active Labor Act) provisions that require an appropriate medical screening exam of all Emergency Room patients. The hospital is found guilty of EMTALA violations, and the man's family receives an award in excess of state caps on malpractice awards due to the distinct federal basis of their claim.

The Department of Health & Human Services investigated the EMTALA claim as well, finds them guilty, and fines the hospital $50,000. The hospital is now required to immediately develop additional Emergency Room protocols or lose their right to participate in the Medicare program.

The story appears in the local newspapers, and eventually ABC Hospital and their insurer will be millions of dollars out of pocket.

Background of the EMTALA laws

In 1985, Congress passed the EMTALA laws in response to a public outcry over perceived "patient dumping." Several widely published studies suggested that large numbers of uninsured individuals were being discharged from emergency rooms in unstable medical conditions simply because of their inability to pay. While the evidence was largely anecdotal in character, Congress acted, and the lives of hospital administrators everywhere took a sharp turn for the worse. Virtually overnight, Congress had imposed new obligations on hospitals and their physicians and opened the floodgates to new litigation by allowing patients to sue hospitals in federal court for EMTALA violations.

EMTALA establishes two major mandatory obligations for hospitals and physicians. First, it imposes a duty on emergency physicians to provide all emergency room patients an "appropriate medical screening exam, reasonably calculated," to detect an "emergency medical condition." Second, it requires emergency physicians to "stabilize" any emergency medical condition prior to transferring a patient, or sign a statement that it is in the patient's best interest to be transferred despite the risk. The Act provides definitions for some of these terms that cannot be squared with the reality of practicing medicine, thus ensuring that the physicians' decisions would be analyzed by experts in hindsight. Under EMTALA, plaintiffs no longer have to demonstrate malpractice if they can show the physician violated EMTALA regulations.

The following is a guideline of hospital requirements under EMTALA:

- All patients presenting in the emergency room must be given an appropriate medical screening reasonably calculated to detect an emergency medical condition. (42 U.S.C. §1395dd(a).)
- The appropriate medical screening must not only be reasonably calculated to detect emergency medical conditions, but must also make use of all appropriate, available diagnostic aids and specialty consultations. The exam, however, may focus exclusively on the patient's description of symptoms and the those conditions identified by the physician. It does not have to include signs and symptoms of which the physician is not made aware or which the physician might have reasonably overlooked. (42 U.S.C. §1395dd(a).)
- An "emergency medical condition" is defined as one in which "the absence of immediate medical attention would... result in placing the person's health in serious jeopardy, cause serious impairment to bodily functions or cause serious dysfunction to any bodily organ or part." Of course, experts may differ on whether or not any condition rises to the level of this definition. (42 U.S.C. §1395dd(e).)
- If an appropriate medical screening is provided, and no emergency medical condition is found, the patient may be transferred for any reason including an inability to pay.
- If a call is made to an on-call physician, that physician must answer the page in a timely fashion and appear to examine the patient at the request of the emergency physician. Failing to respond to a page in a timely fashion is one of the most common allegations of EMTALA violation. Healthcare Financing Agency (HCFA) believes that many illegal transfers result from non-compliance with duties by on-call specialists.
- If the screening turns up a medical emergency, the hospital can transfer the patient only if (a) the patient has been stabilized; i.e. no deterioration is expected to result or occur during the transfer; (42 U.S.C. §1395dd(e)(3)(A)), or (b) the patient needs the treatment available at the receiving facility and the medical benefits of transfer outweigh the risks. This should be documented in writing; (42 U.S.C. §1395dd(c)) and (c) the receiving hospital is capable of providing the necessary treatment and agrees to the

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transfer. Under most state laws, hospitals that are obligated to provide emergency medical care are also required to accept transfers; and, (d) the medical records are sent with the patient.

• If a hospital receives an inappropriate transfer, EMTALA obligates it to report said transfer to federal authorities, typcially HCFA, or the Office of Inspector General (OIG) of the Division of Health and Human Services. Failure to report violations subjects the receiving hospital to the same penalties as the transferring hospital; i.e. $50,000 per violation and/or exclusion from Medicare. (42 C.F.R. §489.20(m)(1997).)

Additional issues

A private cause of action exists when an individual either is not afforded an appropriate medical screening exam upon arrival to the emergency room or is inappropriately transferred and an injury is sustained. If an injury is suffered as a direct result of a violation of either of these requirements, EMTALA grants the plaintiff the right to sue the hospital in federal court. The hospital is strictly liable for violating either of these requirements, and no showing of negligence is necessary.

Moreover, in some jurisdictions an EMTALA claim is not subject to damages caps, arbitration or peer review requirements.

Finally, although emergency physicians are immune from suit by the plaintiff under EMTALA, on-call physicians are not. On-call physicians are treated as agents of the hospital and may be sued in that capacity by the plaintiff for violating either the screening or the transfer requirements.

Even spurious EMTALA complaints may result in serious consequences for the hospital in question. All allegations of EMTALA violations must be investigated. At a minimum, an opportunity has been created for an intrusive inspection of the hospital by DHSS departments, HCFA and OIG, JCAHO (Joint Commission on Accreditation of Hospital Organizations), and others. A mere investigation will disrupt hospital routine and create anxiety over potential findings. At worst, HCFA can revoke the hospital's right to participate in the Medicare system and the OIG can sue in federal court for the application of penalties to the hospital in the amount of $50,000 per violation.

HCFA may condition continued participation in Medicare upon costly protocol review, revision and retraining of hospital staff. Moreover, both federal regulation and case law have extended the application of EMTALA beyond its original intent as expressed by Congress in the Congressional Record. EMTALA, as interpreted by the courts and pursuant to federal regulations, applies to every person entering an emergency room, regardless of ability to pay or insurance coverage, and every person transferred from a hospital, whether they are transferred from the emergency room or from any other hospital department.

The implications of EMTALA for the medical malpractice attorney are obvious. By including any potentially viable EMTALA violation in a complaint, the attorney gains a powerful bargaining chip vis-a-vis the hospital. Because it is sufficient to merely demonstrate that a violation occurred in order to recover and potentially trigger potential fines, costly protocol review, DHSS and JCAHO inspection and possible expulsion from Medicare participation, the hospital runs a tremendous risk in allowing the plaintiff to go to court and thus has a greater incentive to settle.

An excellent guide to EMTALA is Moy, Mark, The EMTALA Answer Book, Aspen Publishers Inc., (1999, 3d ed.).

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