

DEATH AND INJURY BY DELAY: HIDDEN HARM AND EMTALA'S REVERSE DUMPING

PROVISION

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I. INTRODUCTION

The title of this paper reflects my personal experience with the Emergency Medical Treatment and Active Labor Act's (EMTALA) provision regarding "reverse dumping" – also known as the failure of a hospital to accept an emergently ill patient. I believe that EMTALA remains the single most important piece of legislation affecting emergency medicine passed in my twenty-five years of practice in the specialty. The title also references two issues involving reverse dumping: (1) the carelessly written inter-hospital emergency patient transfer policies that may result in significant patient harm through unnecessary delays in patient transfers, and (2) the fact that such patient harm goes unnoticed or is hidden on many occasions. Only in the rare catastrophic case resulting in significant injury or death, does the consequence of reverse dumping reveal itself.

Congress enacted EMTALA in 1985.¹ Since then, the courts and regulatory agencies have expanded the scope of EMTALA to include almost every aspect of emergency department services including the transfer-in of emergency patients from other facilities. Of particular interest are EMTALA sections addressing the requirements placed on Medicare-participating, emergency hospitals to evaluate any patient who presents to that emergency department with a medical complaint as well as requirements to stabilize any emergency medical conditions or a

¹ Examination and Treatment for Emergency Medical Conditions and Women in Labor, 42 U.S.C. § 1395dd (1994).

pregnant woman presenting in labor while also restricting transfers and prohibiting delays in treatment to inquire about insurance or method of payment. It also offers protections for whistleblowers.²

Section 1395dd(g) of EMTALA, named the “nondiscrimination clause,” is the topic of this discussion. This provision places responsibility on the receiving hospital to accept emergency transfers from outlying facilities if the receiving hospital has the specialized services and the capacity to meet the transferred patient’s needs.³

Despite this clear responsibility under EMTALA to accept an emergency transfer, many hospitals violate EMTALA rules through inattentiveness or neglect. The most common mistake made by hospitals is placing their on-call medical staff at the front of the process. By doing so, the hospital makes the physician the agent of the hospital who is responsible for carrying out the hospital’s EMTALA obligation. The on-call physician may refuse to accept the transfer for any number of reasons while the hospital remains unaware that the refusal occurred. An inappropriate refusal is called “reverse dumping.” From a regulatory and enforcement standpoint, reverse dumping is part of a broader category called “Patient Dumping.” This broad enforcement category also includes “failure to provide an appropriate medical screening examination or stabilizing treatment” and the “inappropriate” transferring-out of a patient.⁴

These are all EMTALA violations that may expose a hospital to an investigation and possible

² 42 U.S.C. § 1395dd

³ Id., Nondiscrimination: A participating hospital that has specialized capabilities or facilities (such as burn units, shock-trauma units, neonatal intensive care units, or (with respect to rural areas) regional referral centers as identified by the Secretary in regulation) shall not refuse to accept an appropriate transfer of an individual who requires such specialized capabilities or facilities if the hospital has the capacity to treat the individual.

⁴ HHS OIG SEMI-ANNUAL REPORT TO CONGRESS, LEGAL AND INVESTIGATIVE ACTIVITIES RELATED TO MEDICARE AND MEDICAID, Spring 2011.

sanctions. However, it is the emergency patient who is most affected by patient dumping. It is the emergency patient who risks an unnecessary delay in treatment that may lead to increased morbidity and even death.

In Arkansas, emergency medical care is defined by the Definition of Emergency Medical Care Act.⁵ The Act follows EMTALA's mandates by requiring a timely medical screening exam on all patients presenting to an emergency department regardless of their ability to pay. If an emergency condition is detected, appropriate intervention is authorized. The act, however, does not address the patient dumping issues enforced by EMTALA.

The following paragraphs discuss the origin and driving force behind the enactment of EMTALA. After a brief discussion of the law of agency, this paper reviews the seminal case involving reverse dumping. The paper continues with examples of typical cases of reverse dumping, drawn from my own experience as an emergency physician and from incidents resulting in civil monetary penalties imposed by the Office of Inspector General (OIG). This paper concludes with recommendations designed to protect both the patient and the hospital.

II. EMTALA

Robert A. Bitterman, M.D. provides a colorful account of the origins of EMTALA in his outstanding resource compilation, *Providing Emergency Care Under Federal Law: EMTALA*.⁶ In January of 1985, "Eugene 'Red' Barnes, a 32-year-old unemployed mechanic, staggered out of the abandoned Sonny Boy Hotel in Richmond, California, a small town on the north end of San Francisco Bay. During an altercation in this 'shooting gallery' for intravenous drug users,

⁵ Definition of Emergency Medical Care Act, Ark. Code Ann. § 20-9-309 (2005).

⁶ ROBERT A. BITTERMAN, PROVIDING EMERGENCY CARE UNDER FEDERAL LAW: EMTALA (American College of Emergency Physicians 2000).

he had sustained a gaping stab wound to the left side of his head.”⁷ What followed were refusals by neurosurgical consultants and multiple hospitals to offer definitive emergency treatment in order to save Mr. Barnes’ life. After more than four hours, Barnes was transferred to San Francisco General Hospital where he died three days later. This case received local and national media attention. More importantly, the case prompted Representative Pete Stark of Oakland, California, to introduce legislation that ultimately resulted in EMTALA.⁸

EMTALA requires a medical screening exam on any patient presenting to an emergency department with a healthcare complaint, no matter the patient’s insurance coverage or lack of coverage or ability to pay. This screening exam must be performed by a healthcare professional with the authority to order any ancillary tests such as lab or X-Ray. If an emergency medical condition is found, the patient must then be stabilized before any decision is made to admit, transfer, or discharge. If the benefits of immediate transfer (most often to a hospital with specialized capabilities or facilities) outweigh the risks of transfer, the stabilization requirement is waived.⁹

EMTALA requires that “[a] participating hospital that has specialized capabilities or facilities (such as burn units, shock-trauma units, neonatal intensive care units, or regional referral centers as identified by the Secretary in regulation) shall not refuse to accept an appropriate transfer of an individual who requires such specialized capabilities or facilities if the hospital has the capacity to treat the individual.”¹⁰ In other words, the receiving hospital must

⁷ Id. at 7.

⁸ 42 U.S.C. § 1395dd.

⁹ 42 U.S.C. § 1395dd(c)(1)(ii).

¹⁰ 42 U.S.C. § 1395dd(g).

accept the transferring-in patient if the receiving hospital meets two requirements - capacity and specialized capability. Violation of this subsection is commonly called “reverse dumping.”¹¹

III. THE LAW OF AGENCY

Agency is “[a] fiduciary relationship created by express or implied contract or by law, in which one party (the agent) may act on behalf of another party (the principal) and bind that other party by words or actions.”¹² Actual agency is “[a]n agency in which the agent is in fact employed by a principal.”¹³ An agency by estoppel is “an agency created by operation of law and established by a principal’s actions that would reasonably lead a third person to conclude that an agency exists.”¹⁴ An agency by estoppel may also be called an ostensible agency or an apparent agency.¹⁵

A hospital must designate someone acting on the hospital’s behalf to “accept” the patient from the transferring hospital. Frequently by default, this “someone” is the on-call physician in the particular specialty needed to definitively treat the incoming patient. The physician is often unaware of the law of agency or that they act as an agent on the hospital’s behalf. “The refusal of a patient in transfer by tertiary hospitals is one of the fastest growing areas of EMTALA citations against hospitals. The citations usually result from on-call physicians’ improper rejections of appropriate transfers.”¹⁶

¹¹ CONSTANCE H. BAKER, AVOIDING EMTALA WHEELS OF MISFORTUNE, Presentation for American Health Lawyers Association Institute on Medicare and Medicaid Payment Issues, April 3-5, 2002.

¹² *Black’s Law Dictionary* 70 (8th ed. 2009).

¹³ *Id.* at 71.

¹⁴ *Id.*

¹⁵ *Id.*

¹⁶ Bitterman, *supra* note 9, at 111.

EMTALA states in clear language that the receiving hospital is responsible for accepting an emergency patient transfer if that receiving hospital has the capability and capacity to do so. Problems occur when the receiving hospital fails to delineate clearly who has the authority to accept the patient on the receiving hospital's behalf. By custom or ignorance, receiving hospitals continue to place their on-call private medical staff at the front of the process. Most commonly this results in an "apparent agency" situation when the transferring hospital directly contacts the specialty physician on-call for that specialty at the receiving hospital. The on-call physician might refuse the transfer for any number of reasons, most of which are inappropriate. The receiving hospital may be unaware that its agent failed to accept a patient transfer. Nonetheless, the refusal violates EMTALA and, if discovered, may result in sanctions, fines, or both.

Ostensible or apparent agency arises frequently in hospital-physician relationships. Hospitals are liable for all negligent acts of their employees committed within the scope of employment, even if the acts involve individual judgment. In some situations, even if the physician is an independent practitioner who is not an employee of the hospital but works in the hospital's emergency room, the hospital may be held liable for the physician's negligence.¹⁷ On-call physicians are obligated to take unassigned calls as part of their hospital privileges. This on-call physician list, a requirement of EMTALA, is organized by specialty coverage and overseen by the hospital. The on-call physician list is required by EMTALA for all participating

¹⁷ *Jackson v. Power*, 743 P.2d 1367, 1377 (Alaska 1987) (holding the hospital had a non-delegable duty to provide non-negligent physician care in its emergency room and, therefore, may be liable).

hospitals.¹⁸ The hospitals must “maintain a list of physicians who are on-call for stabilization of a patient with an emergency medical condition.”¹⁹

When an on-call physician refuses the transfer, the emergency physician at the transferring hospital must scramble to find a way around the uncooperative on-call physician or find a similarly suitable hospital to accept the patient. In a life-threatening emergency, this creates an untenable situation placing the patient in jeopardy and the receiving hospital at risk for an EMTALA violation. Such an event occurred in Oklahoma in 1995 resulting in the seminal case of reverse dumping.

IV. ENFORCEMENT

The Centers for Medicare & Medicaid Services (CMS) oversees compliance with EMTALA. Residing within the Department of Health and Human Services, CMS investigates all complaints regarding EMTALA violations. When a hospital receives an EMTALA complaint, CMS sends specially trained investigators to the facility. These field investigators are usually state-level Department of Health employees. The investigators interview the patient or person filing the complaint along with the physicians and nurses involved. Hospital transfer policies are also examined for compliance. Any violations receive a notice of corrective action, and the hospital has a reasonable time frame (ninety days) to provide a compliance plan. The violation is then referred to the OIG for possible civil monetary penalties.

CMS Region 6 is located in Dallas, Texas but covers Arkansas, Louisiana, New Mexico, Oklahoma as well as Texas. Between January 1, 2006 and December 31, 2010, Region 6

¹⁸Agreements with Providers of Services; Enrollment Processes, 45 U.S.C. § 1395cc (2011).

¹⁹ Erin M. McHugh, Note, *The New EMTALA Regulations and the On-Call Physician Shortage: In Defense of the Regulations*, 37 Health L. 61 (Winter 2004).

received reports of 511 alleged violations, finding 183 incidents to be valid.²⁰ Of these violations, 113 involved patient dumping.²¹ Fifty-one (51) hospitals received a confirmed violation.²²

The OIG enforces sanctions and civil monetary damages against violators.²³ These monetary penalties are not to exceed \$50,000 and the OIG “must follow a specific procedure to obtain civil monetary damages.”²⁴ “The respondent hospital or physician has the right to request an administrative law judge (ALJ) within the Department of Health and Human Services (HHS).” The OIG cited “only twenty-three (23) EMTALA enforcement actions” in 2002.²⁵ Most all cases involving civil monetary penalties are settled. In 2010, the OIG settled just seven cases, all without any findings being “made against the settling party.”²⁶ This small number suggests that the cases are under-reported and not aggressively pursued.

The OIG reported in its Semiannual Report to Congress covering October 1, 2010 to March 31, 2011 only four cases involving patient dumping were assessed civil monetary penalties.²⁷ Of these, two involved reverse dumping.

²⁰ FOIA (5 U.S.C. § 552) request to CMS Region 6 office (March 10, 2011).

²¹ *Id.*

²² *Id.*

²³ McHugh *supra* note 19.

²⁴ *Id.* at 74.

²⁵ *Id.*

²⁶ OFFICER OF INSPECTOR GENERAL, U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES, PATIENT DUMPING, http://oig.hhs.gov/fraud/enforcement/cmp/patient_dumping.asp (accessed September 1, 2013).

²⁷ OFFICE OF INSPECTOR GENERAL SEMIANNUAL REPORT TO CONGRESS, OCTOBER 1, 2010 – MARCH 31, 2011, U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES, WASHINGTON D.C., http://oig.hhs.gov/reports-and-publications/archives/semiannual/2011/spring/spring2011_semiannual.pdf (accessed September 1, 2013).

V. THE SEMINAL CASE

The seminal case is *St. Anthony Hosp. v. United States Department of Health and Human Services*.²⁸ In this, an individual (hereinafter referred to as R.M.) was involved in an automobile accident on April 8, 1995 while traveling on a highway near Shawnee, Oklahoma. R.M. suffering from a traumatic injury to his abdominal aorta, was taken to the nearest emergency room located at Shawnee Regional Hospital.

Shawnee Regional Hospital's ("Shawnee Regional") medical staff contained no physician specialist capable of treating this condition, nor did Shawnee Regional possess the appropriate facilities and services required for managing this condition. The emergency room physician at Shawnee Regional, Dr. Carl Spengler, made several phone calls to arrange an emergency transfer of R.M. One of those calls was to St. Anthony Hospital in Oklahoma City. St. Anthony's had the specialized capabilities to perform vascular surgery and possessed the available capacity to treat R.M.

Dr. Spengler contacted St. Anthony's and spoke with Dr. Billy Joe Buffington, an emergency medicine physician working in that hospital's ER. Although Dr. Buffington carried express authority from St. Anthony to accept emergency patients from a transferring hospital, he deferred the decision to Dr. Scott Lucas, the thoracic-vascular surgeon on-call for St. Anthony, who allegedly refused to accept the transfer of R.M.

Spengler ultimately transferred R.M. to Presbyterian Hospital in Oklahoma City where R.M. immediately underwent surgery for a traumatic occlusion of the abdominal aorta.

²⁸ *St. Anthony Hosp. v. U.S. Dep't. of Health and Human Servs.*, 309 F. 3d 680 (10th Cir. 2002).

Revascularization failed and R.M. lost both legs to above the knee amputations. R.M. died April 11, 1995.²⁹

After an investigation, the Inspector General (I.G.) found St. Anthony violated section 1867(g) of the Social Security Act (i.e., the Examination and Treatment for Emergency Medical Conditions and Women in Labor Act, 42 U.S.C 1395dd). St. Anthony appealed the IG's findings and assessment of Civil Monetary Penalties to the Department of Health and Human Services. Departmental Appeals Board Administrative Law Judge Steven T. Kessel heard the appeal.

Finding that Respondent had the "specialized capabilities and facilities to treat R.M.", and that Respondent had the "capacity to treat R.M.", the judge held that "Respondent refused to accept an appropriate transfer of R.M."³⁰ "Respondent did not train its staff or its on-call physicians as to their obligations to assure compliance by Respondent with section 1867(g) (42 U.S.C § 1395dd) of the Act. Dr. Lucas never received any training concerning section 1867 of the Act. Left adrift by Respondent, Drs. Buffington and Lucas made decisions on the evening of April 8, 1995, which caused Respondent to fail to comply with the Act."³¹ Judge Kessel imposed Civil Monetary Penalties of \$25,000.³²

The Appellate Division of the Departmental Appeals Board affirmed the decision of Judge Kessel, but increased the fine to \$35,000. The Appellate Division held that "while the ALJ properly recognized that remediation may lawfully be considered as a mitigating factor in setting the CMP amount, the remedial acts cited by the ALJ were taken by St. Anthony in order

²⁹ *St. Anthony Hosp. v. The Inspector Gen.*, DAB 1728 (Dep't. of Health and Human Servs., June 5, 2000) <http://www.hhs.gov/dab/decisions/dab1728.html>, (accessed September 1, 2013).

³⁰ *Id.* at 22.

³¹ *Id.* at 30.

³² *Id.* at 33.

to avoid termination from the Medicare program, rather than due to a resolution on St. Anthony's part to change to improve its compliance with the law."³³

St. Anthony petitioned the 10th Circuit to set aside the decision of the Department of Health and Human Services ("HHS"). Holding that the "hospital was bound by its physician's refusal to accept transfer of patient" and that the "imposition of \$35,000 penalty was supported by evidence," the Court denied the petition to set aside the decision of HHS.³⁴

VI. POST ST. ANTHONY

Two similar cases occurred following the *St. Anthony* decision in a large community hospital ER where I served in both a clinical and an administrative role. My presentation of the cases to the Medical Executive Committee of this hospital resulted in minor changes to the hospital's transfer policy.

One of the cases is disturbingly similar to the *St. Anthony* case. An elderly patient fainted at home. EMS arrived at the patient's house and made the tentative diagnosis of a rupturing abdominal aortic aneurysm. EMS then transported the patient to the closest hospital, a small rural hospital that lacked the capabilities of dealing with such an emergency. The ER physician stabilized the patient to the best of his ability and called the receiving hospital, Hospital X. The on-call vascular surgeon at Hospital X returned the phone call, but immediately questioned the ER physician's presentation of the patient. The vascular surgeon faulted the lack of any radiographic or ultrasound procedure confirming the diagnosis. The small hospital had no computerized tomography (CT) scan capability, and only had ultrasound available by call-in (a thirty minute or greater delay). Despite the clinical diagnosis made by a paramedic at the patient's home, Hospital X's vascular surgeon refused to accept the patient.

³³ *Id.*

³⁴ *St. Anthony Hosp v. U.S. Dep't. of Health and Human Servs.*, 309 F. 3d 680.

By going up the chain-of-command, the emergency physician ultimately arranged for the patient transfer. The Chief of Staff, a surgeon at Hospital X, accepted the patient on behalf of the hospital. Upon the patient's arrival to Hospital X, ultrasound revealed a dissecting abdominal aortic aneurysm leaking blood into the abdominal cavity. The vascular surgeon, who refused the patient just hours before, arrived at the completion of the ultrasound and rushed the patient to the operating room. Because of the urgency of the situation, the vascular surgeon used a makeshift staff composed of ER nurses. The patient died on the operating table. The total delay, from the paramedic's diagnosis at the patient's house until the first surgical excision, exceeded four hours. The vascular surgeon faced no peer review or counseling.

A few months after this event, another patient suffered from Hospital X's lack of an effective transfer policy. A sixty-five year old patient presented to a rural ER with a stroke-in-evolution. A stroke-in-evolution is an acute presentation of paralysis on one side of the body. This may be caused by a blood clot in a major vessel of the brain.³⁵ With prompt action within the first three hours from onset, "clot-busting" drugs may be employed to dissolve the clot and return the patient to normal function. However, about one stroke out of five results in the blood vessel breaking, and a subsequent hemorrhage of blood into the brain tissue occurs.³⁶ The clot-busting drugs, or any drugs that interfere with blood clotting, create a significant risk of a catastrophic intracranial bleed resulting in the patient's death.³⁷

³⁵ Cerebral Thrombosis

³⁶ Hemorrhagic Stroke In-Depth Report, THE NEW YORK TIMES, <http://health.nytimes.com/health/guides/disease/hemorrhagic-stroke/print.html> (accessed September 1, 2013).

³⁷ *Id.*

Knowing that the patient's stroke was evolving, the emergency physician acted quickly to transfer the patient to Hospital X. The neurologist on call for Hospital X returned the emergency physician's call, and refused the patient transfer for two reasons: (1) the neurologist did not use "clot-busting" drugs; and (2) the stroke could be handled at the rural hospital. Although the emergency physician explained to the neurologist that the rural hospital had no CT scanner, the neurologist continued to refuse the patient. In an attempt to provide some treatment for this patient with an evolving stroke, the ER physician treated the patient with heparin, a drug that interferes with blood clotting. Unfortunately, the patient had a hemorrhagic stroke and expired within sixty minutes of treatment.

These catastrophic and unnecessary events continue. A Pennsylvania hospital settled a suit in 2010 based on similar circumstances. Marcus Murray, a fifty-six year old man experienced chest pain and weakness while driving home from work. EMS transported him to Underwood Memorial Hospital in Gloucester County. Upon arrival to the Underwood ER at 7:27 p.m., the ER nurse noted Mr. Murray was "pale, sweating profusely and complaining of chest pain and shortness of breath."³⁸ The blood pressure measured "low."³⁹ A CT scan was performed at 10:50 p.m., demonstrating Mr. Murray suffered from a dissecting aortic aneurysm. Immediately, at 10:54 p.m., a transfer to The Hospital of the University of Pennsylvania was arranged, as Underwood Memorial did not possess the capability to manage Mr. Murray's condition.⁴⁰

³⁸ Josh Goldstein, "Penn Hospital Sued Over Failure to Admit Patient", PHILADELPHIA INQUIRER, Mar. 3, 2010 at B01.

³⁹ *Id.*

⁴⁰ *Id.*

Inclement weather precluded the helicopter transport of Mr. Murray.⁴¹ Underwood Memorial’s emergency physician noted at 11:56 p.m. that Dr. Woo, the University of Pennsylvania surgeon, refused Mr. Murray’s transfer “due to various reasons.”⁴² “A nurse’s note in Murray’s records at 11:56 p.m. said Penn ‘refused to accept patient due to no medical insurance.’”⁴³ The patient arrived at Christiana Hospital in Delaware at 1:44 a.m. on May 3 and suffered a cardiac arrest on the operating table.⁴⁴ He survived but suffered brain damage and is blind.⁴⁵

Most of the civil monetary penalties imposed by the OIG have a similar theme to the cases above. Where detailed information is available, the facts show that an on-call physician refused to accept the patient in transfer.

- “Matthew Pearson, M.D., Tennessee, agreed to pay \$35,000 to resolve [his] liability for Civil Monetary Penalties (CMP) under the patient dumping statute. The OIG alleged that Dr. Pearson, while on call at Vanderbilt University Medical Center (Vanderbilt), refused to accept an appropriate transfer of an individual with an unstable emergency medical condition who required the specialized capabilities that were available at Vanderbilt. The patient was transferred to another facility and died shortly thereafter.”⁴⁶
- Vanderbilt University Medical Center (Vanderbilt), Tennessee, agreed to pay \$45,000 to resolve its liability for Civil Monetary Penalties (CMP) under the patient dumping

⁴¹ *Id.*

⁴² *Id.*

⁴³ *Id.*

⁴⁴ *Id.*

⁴⁵ *Id.*

⁴⁶ OFFICER OF INSPECTOR GENERAL, DEPARTMENT OF HEALTH AND HUMAN SERVICES, SUMMARIES: PATIENT DUMPING, 2011 WL 7628473 (2011).

statute. The OIG alleged that Vanderbilt refused to accept an appropriate transfer of an individual with an unstable emergency medical condition who required the specialized capabilities that were available at Vanderbilt. The patient was transferred to another facility and died shortly thereafter.⁴⁷

Where the information offered by the OIG is less detailed, the catastrophic results are often not:

- Springhill Medical Center (CMC), [Mobile] Alabama, agreed to pay \$45,000 to resolve its liability for CMP under the patient dumping statute. The OIG alleged that SMC failed to accept an appropriate transfer of a patient with acute upper gastrointestinal bleeding. The patient was accepted by another hospital approximately 100 miles away and expired the next day.⁴⁸
- Mobile Infirmary (MI), [Mobile] Alabama, agreed to pay \$45,000 to resolve its liability for CMP under the patient dumping statute. The OIG alleged that MI refused to accept an appropriate transfer to its hospital of a patient in need of specialized capabilities available at MI. The refusal of the transfer request delayed care and treatment for a patient's gastrointestinal bleed. Two hours after the request to MI, the patient was finally transferred to another hospital approximately 60 miles away. En route, the patient's condition deteriorated and the patient had to be transported by helicopter to the receiving hospital. The patient subsequently died that day.⁴⁹
- The University of Chicago Hospitals (UCH), [Chicago] Illinois, agreed to pay \$35,000 to resolve its liability for CMPs under the patient dumping statute. The OIG

⁴⁷ *Id.* at 1.

⁴⁸ *Id.* at 2.

⁴⁹ *Id.* at 3.

alleged that the hospital failed to accept an appropriate transfer of a 61-year-old male who presented to another emergency department with a complaint of flank pain. UCH had specialized capabilities not available to the transferring hospital and allegedly refused to accept transfer after learning that the patient did not have insurance. UCH then later agreed to accept transfer of the patient only if he provided proof of funds in a bank account. The patient was transferred to another hospital where he died.⁵⁰

VII. PROFFERED SOLUTIONS IN THE LEGAL LITERATURE

“Under EMTALA, an individual who has suffered personal harm resulting from a violation can sue the hospital, but not the doctor responsible.”⁵¹ Individuals like Lawrence Bluestone argue for an intentional tort of patient dumping against the hospital and the physician, advocating public policy issues of tort law to “recompense those who are harmed and to deter future wrongful action.”⁵² Bluestone points out that “without potential tort liability, profit driven entities may find it cost-effective to engage in behaviors that pose unreasonable threats to human society.”⁵³ Arguing for extending the tort against physicians, Bluestone believes “deterrence must be enforced against the individual who is causing harm. It was recognized early on that hospitals, despite punishment, may have the economic incentive to dump patients. Individual physicians on the other hand would not have the economic incentive to do so if they are

⁵⁰ Archives – Patient Dumping, Office of the Inspector General, http://oig.hhs.gov/reports-and-publications/archives/enforcement/patient_dumping_archive.asp#2006 (accessed September 1, 2013).

⁵¹ Lawrence Bluestone, *Straddling the Line of Medical Malpractice: Why There Should Be a Private Cause of Action Against Physicians Via EMTALA*, 28 *Cardozo L. Rev.* 2829, 2831 (2007).

⁵² *Id.* at 2849.

⁵³ *Id.*

appropriately deterred. While the hospital may be liable for a policy that encourages such action, it is the doctor who is guilty of intentional wrongdoing in the tortious sense.”⁵⁴

Bluestone’s intentional tort solution offers an alternative to my statutory solution proposed in the introduction. Intentional tort requires the elements of causation, injury and damages plus “intent” to be present.⁵⁵ How could a vascular surgeon, possessing the needed life-saving skills of his professional specialty and without a reasonable basis, refuse a critically ill patient with a rupturing aneurysm? The vascular surgeon must know or should know that this refusal prolongs the patient’s access to needed definitive care and threatens the patient’s life. How can a large community hospital or a tertiary care hospital refuse to enact effective educational efforts and policy changes to assure compliance with EMTALA, knowing the risk of potential harm to patients in need of the facilities specialty care?

Ercan E. Iscan takes the opposite view and would “allow transferee hospitals the option of refusing a transfer if there are other comparable facilities available to accept the patient.”⁵⁶ Iscan argues, “a balance must be struck between Congress’s concerns for public welfare and the economic realities of modern day health care”.⁵⁷ He suggests reforming EMTALA so “the transferee hospital would be exempt from accepting the patient if the transferring hospital could make alternate arrangements within a reasonable amount of time.”⁵⁸ Under his reform proposals, “a particular transferee hospital would not be saddled with the responsibility for taking on a

⁵⁴ *Id.* at 2858.

⁵⁵ RESTATEMENT (SECOND) OF TORTS § 8A (1965) (The word “intent” is used throughout the Restatement of this Subject to denote that the actor desires to cause consequences of his act, or that he believes that the consequences are substantially certain to result from it.)

⁵⁶ Ercan E. Iscan, *EMTALA’S Oft-Overlooked “Reverse Dumping” Provision and the Implications for Transferee Hospital Liability Following St. Anthony Hospital*, 82 Wash. U. L.Q. 1201, 1222 (2004).

⁵⁷ *Id.* at 1221.

⁵⁸ *Id.* at 1222.

potentially indigent patient just because it is at the top of an attending physician's speed dial list at a small local clinic."⁵⁹ Iscan neither explains how EMTALA applies to "small local clinics" nor bothers to define "a reasonable amount of time."

Iscan fails to understand that timeliness of the transfer of a critical patient is the primary goal in preventing reverse dumping. A dissecting aneurysm, multiple trauma victims, an acute myocardial infarction (heart attack), posterior dislocation of the knee, acute epidural hematoma (head bleed), respiratory failure with ventilator and ICU requirements, acute stroke within three hours of onset, and other conditions too numerous to list are time sensitive and require immediate definitive care. Large community hospitals, university hospitals, and children's hospitals are the facilities with the capability to treat such patients. The emergency room attending physician at the referring hospital needs a prompt response from these facilities to accept the critically ill patient in transfer. Anything less than a prompt response endangers lives.

VIII. RECOMMENDATIONS

The underlying problem in all the cases above is the hospital's lack of control in the transfer process. Most hospitals design their transfer policy around § 1395dd(c) of EMTALA, focusing on transferring-out an emergency patient instead of receiving-in an emergency patient. In doing so, the hospital gives only cursory attention to § 1395dd(g) involving the acceptance of an emergency patient from the transferring facility. The key point is that the receiving hospital **shall not** refuse an appropriate transfer if the receiving hospital has capacity plus specialized capabilities or facilities.

⁵⁹ *Id.*

I propose a statutory solution to this problem in Arkansas by amending the “Definition of Emergency Medical Care Act” to include subsection (e) dealing with inter-hospital transfer of patients with emergency medical conditions.

(e) Each hospital licensed in Arkansas must submit a transfer policy that covers the process of transferring a patient out of the facility’s emergency department and receiving a transfer into the facility from an outside hospital’s emergency department. The process of receiving a transfer into the facility must meet the following requirements:

1. Be compliant with 42 U.S.C. § 1395dd, Examination and Treatment for Emergency Medical Conditions and Women in Labor;
2. Designate an employee, or agent, of the hospital, by position, to accept the patient on the hospital’s behalf;
3. Record all professional-to-professional reports of the transfer; and
4. Maintain an emergency appeal process for immediate activation to the on-call executive representative of the hospital regarding any refusal of a patient transfer.
5. In lieu of a formal process, the hospital may outsource its transfer process to a central transfer center that meets the minimum requirements listed above.

An appropriate transfer policy should do the following:

1. Designate the hospital’s agent for accepting transfers (with proper training in the responsibility’s requirements). This can be the house supervisor, the ER doctor on duty, a transfer center operator, or the on-call medical staff;
2. Assure the designated agent has complete authority to accept transferring-in emergency patients as long as the requirements of capacity and specialized capability are met; and
3. Clearly state in the policy how the hospital’s agent is educated on EMTALA law and trained in the responsibility of the transferee hospital to accept emergency transfers.

The best method to assure compliance with EMTALA’s § 1395dd(g) is to establish a Transfer Center. The Transfer Center accepts all transfer requests for the hospital assuring the availability of capacity and capability to treat the patient. All phone calls are recorded between the transferring facility and its healthcare providers as well as those between the receiving

facility and its healthcare providers. The transfer center arranges the physician-to-physician report and the facility-to-facility report. Any failure to accept a transfer is immediately addressed and evaluated for compliance. If the transfer is inappropriately denied, the receiving facility immediately corrects the error and follows with peer review and education to assure future compliance with EMTALA. Patient care is enhanced and hospital compliance assured.

Arkansas has an opportunity to establish a centralized transfer center offering many advantages to its citizens and to hospital facilities. With a centralized center, the status of hospitals with specialized capabilities or facilities could be continuously updated regarding their capacity to treat emergently injured or ill patients. A “one call” system is possible for the transferring hospital, and the emergently ill or injured patient could be immediately sent to the proper healthcare facility. There would be no unnecessary delays in the patient receiving definitive care for their time-sensitive emergent condition. Arkansas should adopt the proposed changes to its Definition of Emergency Medical Care Act.