It's Not Over until It's Over: Reconsideration Denied

Kathleen Ream, Director of Government Affairs

An August 2009 decision by the U.S. District Court for the Northern District of West Virginia granted in part and denied in part the defendant's motion for summary judgment of claims, brought by a driver involved in a racetrack accident, alleging that a hospital violated EMTALA screening and stabilization requirements (Ramonas v. West Virginia University Hospital-East, N.D. W.Va., No. 3:08-cv-136, 8/7/09). Following the August decision, plaintiff George Ramonas submitted a motion to the federal district court seeking reconsideration of the portion of the court's decision in which summary judgment was granted in favor of defendant Jefferson Memorial Hospital (JMH). On October 13, 2009, the court denied plaintiff's motion to reconsider and affirmed its August order granting in part and denying in part the defendant's motion for summary judgment (Ramonas v. West Virginia University Hospitals-East, N.D. W.Va., No. 3:08-cv-136, 10/13/09).

In examining all the relevant facts and applicable standards for disposition of EMTALA cases, the court iterated in no uncertain terms that plaintiff's claims fell short. The court decision carefully describes the plaintiff's flaws in reasoning, and even suggests better logic as demonstrated by the following excerpt regarding the plaintiff urging the court to reconsider its ruling that no disparate treatment has been established:

"…EMTALA's requirement that individuals seeking emergency care receive an 'appropriate screening examination' obligates hospitals to 'apply uniform screening procedures to all individuals coming to the emergency room'…Here, the plaintiff attempts to assert a violation of this requirement by alleging that Ramonas received less screening, both in quantity and quality, than required by JHM's own policies rather than comparing it to those other patients presenting these same medical conditions. A more properly stated claim under EMTALA's screening provision would follow as such: Ramonas received less treatment than 'other patients presenting in this same medical condition,' which would invoke the language of disparate treatment, the linchpin of an EMTALA claim. The argument runs essentially as follows: Ramonas arrived at the emergency room with 'severe' pain; patients who suffer from such severe pain normally undergo diagnostic testing for internal injury; because Ramonas received only pain treatment and not testing for internal injuries, he was treated disparately from other individuals presenting in the same medical condition."

Texas District Court Dismisses Inappropriate Screening and Transfer Claims

On June 16, 2009, the U.S. District Court for the Southern District of Texas found that a hospital did not violate EMTALA in handling a boy treated and later transferred by the hospital's emergency department (Guzman v. Memorial Hermann Hospital System, S.D. Tex., No. 4:07-cv-3973, 6/16/09).

The Facts

Feeling ill on February 12, 2006, seven year old Tristan was taken to the ED at Memorial Hermann in Houston, Texas, by his mother, Wendy Guzman. Arriving at the hospital at 7:39 a.m., they were taken to the triage area. Guzman reported that her son had vomited during the night and had been running a fever. The triage nurse recorded the child's temperature as 98.1 degrees, his blood pressure as 110/67, and his heart rate as 145. Under Memorial Hermann policy, all pediatric patients with a heart rate above 140 are categorized as Emergent Level 2 and must be seen by a physician. In accordance with this policy, the nurse took the child to an examination room to be seen by Dr. Haynes.

At 8:00 a.m., Haynes first took Tristan's medical history, learning that the boy had been coughing, vomiting and complaining of nausea. Haynes examined Tristan, determining that the child was "clinically stable and his saturation on room air was normal. He had clear breath sounds bilaterally, had no retractions, was in no respiratory distress."

Believing that Tristan likely had a virus, Haynes ordered several laboratory tests, including a complete blood count (CBC). Since the automated processor for the CBC had generated an abnormality flag, a manual white blood cell differential test was required. Although the manual test results were available by 9:35 a.m., Haynes did not see them that day. Haynes did check on Tristan, ensuring that he was getting fluids and everything he needed. Haynes also was told that the Guzmans were interested in going home, wanted to know their son's lab values, and what the doctor planned. By 9:58 a.m., Tristan's heart rate had decreased to 105-110, leading Haynes to believe the earlier elevated heart rate had been caused by an inhaler treatment or slight dehydration from vomiting. Absent knowing the white blood cell differential test results, Haynes diagnosed viral syndrome. Haynes made the decision to discharge, and Tristan was released from the hospital at approximately 10:15 a.m.

Upon discharge, Haynes told the Guzmans that their son's condition should begin to improve within 24 hours but to return to the ED if it did not. The Guzmans brought their son back to the Memorial Hermann ED the following morning, February 13, 2006, arriving around 7:00 a.m. Tristan was complaining of fever, abdominal and chest pain, was vomiting, and had diarrhea. Classified again as Emergent Level 2, Tristan was placed in an exam room. Dr. Mohammed Siddiqi performed a physical examination, ordering laboratory tests and a chest X-ray. After examining the test results, Siddiqi diagnosed Tristan with pneumonia around 9:45 a.m.

Tristan's condition worsened. At 11:23 a.m., Siddiqi ordered Tristan transferred to the pediatric intensive care unit. At 12:03 p.m., with a pulse of 148, blood pressure at 85/62, and respiratory rate of 48, Siddiqi first suspected that Tristan may have sepsis. At 12:30 p.m., Memorial Hermann Children's accepted the transfer request but indicated that a "Response in 30 min." would not occur due to the "Extenuating Circumstance" of "Bed Control." By 1:00 p.m., however, the child's pulse was 162, his respiratory rate was 62, and his temperature was 99.1 degrees. Twenty minutes later, Siddiqi came to re-evaluate Tristan and discuss the transfer process with the Guzmans. Deciding at 1:35 p.m. that Tristan needed to be intubated to protect his airway and respiratory system, Siddiqi "thoroughly explained [the] need for intubation to [the] patient's parents, who verbalize[d] understanding."

Shortly thereafter, Siddiqi spoke with Dr. Erickson at Memorial Hermann Children's Hospital, who told Siddiqi that he would first have to prepare a bed in the pediatric ICU. Erickson also told Dr. Siddiqi that he wanted the child to be transported by the Memorial Hermann Children's pediatric transport team, but that the team was currently en route to Beaumont, Texas, to pick up another patient. Siddiqi was aware of the time it would take to transfer Tristan, but agreed with Erickson that the pediatric transport would be better, and so

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decided to wait. Siddiqi intubated Tristan at 1:50 p.m. The standard ambulance team arrived at 2:25 p.m. Siddiqi called Erickson, who iterated that he wanted Tristan transported by the pediatric transport team and that there still was no available pediatric ICU bed. At 3:15 p.m., Siddiqi went to "discuss plan of care with patient's parents and [the] delay of transfer."

Tristan then had a severe allergic reaction to one of the medications used for the intubation, causing his body temperature to increase to 107.9 degrees. Siddiqi's shift had ended, so at 3:52 p.m. a nurse notified ED physician Dr. David Nguyen of Tristan's elevated temperature. By 4:00 p.m. Nguyen had ordered cooling blankets, and ice packs were applied. Within five minutes, Tristan's temperature had reached 111.2 degrees. At 4:13 p.m., Nguyen and Erickson spoke, agreeing that Tristan needed to be transported to Memorial Hermann Children's via Life Flight helicopter. The helicopter arrived at 4:45 p.m., transporting Tristan to Memorial Hermann Children's Hospital, where he received immediate care and was hospitalized in the intensive care unit.

Tristan remained at Memorial Hermann Children's Hospital for several weeks. Diagnosed with septic shock, which caused organ injury, Tristan still requires follow-up medical care and therapy. In November 2007, the Guzmans sued Memorial Hermann claiming that the hospital violated EMTALA. In a second amended complaint, Guzman alleged that Memorial Hermann committed three EMTALA violations: failing to provide an "appropriate medical screening examination" on February 12, 2006, when Tristan was examined by Haynes; failing to stabilize the child's emergency medical condition before discharging him that day; and failing to effect an appropriate transfer on February 13, 2006.

The Ruling

The district court granted Memorial Hermann's motion for summary judgment. Specifically, in regard to Guzman's appropriate medical screening claim on the first visit to the ED, the court iterated that "negligence in the screening process or providing a faulty screening or making a misdiagnosis, as opposed to refusing to screen or providing disparate screening, does not violate EMTALA, although it may violate state malpractice law." Finding that "Guzman's allegations and the summary judgment evidence, taken in the light favorable to her, do not as a matter of law support a claim under EMTALA that the screening examination was not appropriate." Thus, summary judgment was granted on Guzman's EMTALA screening claim.

Also on the first visit to the ED, Guzman claimed a failure to stabilize an emergency medical condition. "Whether a patient is in fact suffering from an emergency medical condition is 'irrelevant for purposes of [EMTALA],'" wrote the court. "The statutory language makes clear that 'what matters is the hospital's determination of the patient's medical status. The standard is a subjective one.'" Determining that there was no dispute as to the hospital's actual lack of knowledge of an emergency medical condition and that Guzman did not present any evidence of a difference of opinion within the hospital staff as to Tristan's condition, the district court ruled "Memorial Hermann's motion for partial summary judgment on the EMTALA failure to stabilize claim based on the initial visit to the emergency room is granted."

The appropriate transfer claim on Tristan's second visit to the ED also resulted in the court granting Memorial Hermann's motion for partial summary judgment. Under EMTALA, Memorial Hermann could not transfer Tristan to another hospital unless: 1) the parents requested in writing to be transferred to another hospital; or 2) a physician signed a certification that the medical benefits reasonably expected from medical treatment at another hospital outweighed the risks from the transfer. Although the evidence gave rise to a fact issue as to whether Siddiqi or another member of the Memorial Hermann medical staff told Guzman about the hospital's EMTALA obligations before she signed the form, the court did find ample evidence in the record showing that Siddiqi actually and repeatedly weighed the risks and benefits of transferring Tristan to Memorial Hermann Children's Hospital. "[E]ven though he did not specifically list those risks and benefits, the physician certification requirement was met in this case by undisputed evidence of actual deliberation," the court stated. "The record evidence shows that the transfer in this case was appropriate as a matter of law."

Third Circuit Affirms EMTALA Inapplicable to Later-discovered EMCs

On September 2, 2009, the U.S. Court of Appeals for the Third Circuit affirmed the grant of summary judgment in a case previously decided January 2008 by the U.S. District Court for the Eastern District of Pennsylvania. The Court dismissed the EMTALA claim that several hospitals and physicians failed to stabilize and inappropriately transfer a patient when the patient with a high-risk pregnancy did not present in an emergent state and was not in an emergent state until she began to undergo monitoring at the primary hospital (Torretti v. Main Line Hospitals Inc. d/b/a Paoli Memorial Hospital, 3d Cir., No. 08-1525, 9/2/09).

The Facts

This case concerns appellants Christopher and Honey Torretti's son, Christopher, who was born with severe brain damage after Ms. Torretti's high-risk pregnancy went awry. While her first child was born healthy, both pregnancies were high-risk owing to her insulin-dependent diabetes. Because of her diabetic condition, Torretti's primary obstetrician, Dr. Patricia McConnell, referred Torretti to the Paoli Hospital Perinatal Testing Center (Paoli) for monitoring throughout both pregnancies. Paoli is a center for fetal monitoring and consultation only and is located in a building next to Paoli Hospital, also owned by Main Line Health. The two Main Line Health hospitals are approximately twenty miles apart. (Dr. McConnell is a member of the Peden Group, an obstetrics practice group based out of Lankenau Hospital (Lankenau), which is part of the Main Line Health system.)

In her third trimester, Torretti began having complications, primarily premature contractions. During this time, Torretti's monitoring appointments at Paoli were increased to twice per week; and on one occasion, she was monitored as an outpatient at Lankenau. Two weeks later, on April 30 at a routine monitoring, the Paoli medical staff detected pre-term labor. They directed Torretti to Lankenau where she was hospitalized for three days. On that occasion, she drove herself from Paoli to Lankenau.

Two days prior to a routine monitoring appointment during her 34th week, Torretti phoned McConnell twice, first complaining of contractions and then explaining that she was uncomfortable because of her large size and had noticed a decrease in fetal movement. She asked about the possibility of receiving a therapeutic amniocentesis. McConnell advised Torretti to drink a glass of

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ice water to stir the baby. Torretti detected increased movement. McConnell told Torretti that she could come to Lankenau but that nothing could be accomplished until Monday when she was coming in for a routine appointment. Torretti chose not to go the hospital that weekend, believing her condition was not emergent.

On May 23, the Torrettis drove to Paoli for the routine appointment, which included an ultrasound and a fetal non-stress test. Upon arrival at Paoli, Torretti was feeling general discomfort, but she was not alarmed about her condition and did not feel that she was in an emergent state. Torretti told Dr. Andrew Gerson, a perinatologist on Paoli's staff, about her conversation with McConnell over the weekend, that she had a great deal of discomfort mainly due to her large size and had noticed a decrease in fetal movement. Gerson began the non-stress test, and over a 28-minute period, the test showed no decelerations. About the same time the non-stress test began, Torretti's contractions returned. The non-stress test indicated 16 contractions in the 28 minutes of fetal monitoring, with contractions lasting about 50 to 70 seconds and 1½ to 2½ minutes apart. Gerson was aware of Torretti's diabetic condition, noting also in her medical documents that her abdominal circumference was large, and the fetus weighed approximately eleven pounds. The ultrasound test indicated excess amniotic fluid, but that the fetus "was moving its limbs and body."

Preliminary test results and Torretti's diabetic condition led Gerson to terminate the non-stress test, send Torretti to Lankenau for longer-term monitoring, and consult by telephone with McConnell. Gerson testified that this plan appeared to be "perfectly safe" based on the "best information we had," and that even though Torretti was having contractions, which were commonplace throughout her third trimester, "delivery wasn't necessarily going to be imminent…and it was appropriate for her to go to Lankenau Hospital." While Ms. Torretti determined that "[t]here was no urgency," Mr. Torretti asked whether it was an emergency and if they should travel by ambulance. Gerson replied that it was not that urgent, but he requested that they go directly to Lankenau. En route to Lankenau, however, the Torrettis stopped at their home, making the 20-mile trip between hospitals in about 45 minutes.

Gerson had sent a customary explanatory letter to the Lankenau medical personnel with the Torrettis. Torretti had to wait 15 to 20 minutes for a Lankenau room. When Torretti was first connected to the monitor, her condition seemed to be about the same as it had been at Paoli, but then "it worsened very quickly." Shortly thereafter, another doctor with Torretti's regular Peden Group checked on Torretti and immediately rushed Torretti into surgery. Baby Christopher was birthed via caesarean section, and he had severe brain damage.

The Torrettis sued the hospitals and doctors under EMTALA, as well as state statutory and common-law claims. They asserted a federal question under EMTALA, which places three burdens on a hospital: appropriate medical screening, stabilizing treatment of a known emergency medical condition (EMC), and restricting transfer until a patient is stabilized. Defendants moved for summary judgment on the EMTALA claim. The U.S. District Court for the Eastern District of Pennsylvania ruled that the Torrettis did not offer sufficient evidence to raise a reasonable inference that defendants knew Torretti presented a medical emergency, and thus plaintiffs failed to sustain their burden under EMTALA. The district court granted the motion for summary judgment (Torretti v. Paoli Mem. Hosp., No. 06-3003, E.D. Pa. 01/29/08). Plaintiffs appealed the federal district court decision to Third Circuit Court of Appeals.

The Ruling

The federal appeals court stated that Torretti v. Main Line Hospitals, Inc. presented the court its "first opportunity to confront the Emergency Medical Treatment and Active Labor Act." It ruled that the appeal tested "the boundaries of EMTALA, which is not a federal

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Board of Directors Approves New Ethics Rules

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AAEM Vice President

Over the past two years, the AAEM board of directors has completely revised the Academy's ethics rules. All members should review these new rules, which took effect on January 1, 2010.

Previously, the AAEM bylaws included ethics rules that primarily addressed issues of conflict of interest among officers and board members. The new ethics rules expand the ethics construct to define ethical behaviors in other areas, particularly business practices, and now apply to all members as well as those in leadership positions. Additional descriptions of unethical behaviors, mainly practices that are contradictory to the AAEM vision statement, are included.

The new ethics system is posted on the AAEM website at http://www.aaem.org/aboutaaem/codeofethics.php. It is divided into several sections including:

- General Principles
- Business Ethics
- Conflict of Interest
- Procedures in Ethics

Indrani Sheridan, MD FAAEM, James Li, MD FAAEM, and I, borrowing heavily from the previous ethics rules in the bylaws and the American Medical Association rules where appropriate, developed draft ethics rules. This draft was amended and approved by the board of directors. Finally, the AAEM bylaws were amended to strike the old ethics rules and adopt the new ones.

Some members, especially those who employ other physicians or hold contracts for staffing hospitals, may find that their various contracts are in violation of the ethics rules. Thus, it is important for these physicians to review their contracts in the light of the ethics rules.

Members with questions should contact the AAEM office at info@aaem.org.

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The data showed that 14,969 (35.3%) patients had head CTs performed, and 5.2% had traumatic brain injuries on CT (defined as intracranial hemorrhage or contusion, cerebral edema, infarction, diffuse axonal injury, shearing injury, midline shift, herniation, diathesis of the skull, pneumocephalus, sinus thrombosis or depressed skull fracture). Prediction criteria for children under age two who developed ciTBI included altered mental status, non-frontal scalp hematoma, loss of consciousness for more than five seconds, severe injury mechanism, palpable skull fracture and abnormal behavior. For children aged two years and older, predictors include altered mental status, loss of consciousness, vomiting, severe injury mechanism, signs of basilar skull fracture and severe headache. Severe injury mechanism was defined as motor vehicle crash with rollover or patient ejection, death of another passenger, pedestrian or unhelmeted bicyclist struck by a motor vehicle, fall more than three feet in those less than two years old, fall more than five feet in those two years of age or older or head struck by high-impact object. If all of the criteria are negative, then the negative predictive value and sensitivity for predicting ciTBIs in those under two years of age were 100% and 100%, respectively; and for those two years of age and older, they were 99.5% and 96.8%, respectively.

The authors state that if the rules had been applied to the patients in this study, 25% of the head CTs would have been avoided. Interestingly enough, for those under two years old with altered mental status or palpable skull fracture, the risk of ciTBI was as high as 4.4%. Although these prediction criteria are helpful to risk-stratify patients, this study must be reproduced and validated in different populations. As with all clinical prediction rules, the purpose is not to replace clinical decision-making but to inform the clinician.

Tauber M, Koller H, Moroder P. Secondary intracranial hemorrhage after mild head injury in patients with low-dose acetylsalicylate acid prophylaxis. J Trauma. 2009; 67(2):521-525.

Low dose acetylsalicylic acid (LDA) prophylaxis is commonly used for patients with ischemic heart disease, cerebrovascular disease and peripheral vascular disease, among other reasons. The relationship between the use of LDA and the risk for intracranial bleeding after head trauma has not been clearly defined. This study sought to evaluate the prevalence of secondary intracranial hemorrhage after head trauma in patients taking LDA.

This was a single-center prospective study at a level one trauma center in Austria. One hundred consecutive subjects were enrolled who met the inclusion criteria of age over 65, taking regular LDA-prophylaxis (100mg/d), isolated mild head injury with a GCS of 15, preliminarily negative head CT, and no hypertensive irregularities (systolic blood pressure over 150 mmHg). Exclusion criteria included use of clopidogrel, warfarin or NSAIDs, hematologic or oncologic disease, and moderate or severe head injuries. Regular repeat head CT (RRHCT) were done for all patients within 12-24 hours.

Results of the RRHCT showed that four patients developed a secondary intracranial hemorrhagic event (SIHE), one of which was a large intraparenchymal hemorrhage with midline shift resulting in death, and one other who required neurosurgical drainage of a subdural hematoma. The other two patients required no interventions and did well. Initial coagulation profiles were similar among those who had SIHE and those who did not. Based on these results, the authors support the decision to have all patients over age 65 on LDA prophylaxis with mild head trauma admitted for observation and have a RRHCT in 12 to 24 hours. If RRHCT is not done, then the patient should be observed for more than 48 hours.

There were many limitations to this study. First, this small prospective study did not have a matched control group not taking LDA for comparison. Also, mild head injury was never defined. In addition, patients were included if they were admitted to the hospital, and this may represent a selection bias, studying a more acute subset of patients. Finally, other co-morbidities were not considered in the study. Before the recommendation can be made to admit all patients over age 65, further studies must be done.

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malpractice statute…[and] relief for Christopher Torretti's traumatic brain injuries may be available in other forms, but is not provided under EMTALA."

In affirming the trial court's ruling, the appellate court reviewed EMTALA, as well as the Department of Health and Human Services' Centers for Medicare and Medicaid Services (CMS) regulations promulgated to interpret and apply EMTALA. Turning to the regulation's interpretation of the statute, the court wrote: "EMTALA's requirements are triggered when an 'individual' comes to the emergency department. An 'individual' only 'comes to the emergency department' if that person is not already a 'patient'… The Regulation defines 'patient'…as '[a]n individual who has begun to receive outpatient services as part of an encounter… CMS explains that EMTALA does not apply to outpatients, even if during an outpatient encounter 'they are later found to have an emergency medical condition…[and] are transported to the hospital's dedicated emergency department.'" The court then iterated the fact that Torretti "came to Paoli for her scheduled appointment involving routine monitoring of her high-risk pregnancy and did not present as an emergency to the Paoli medical staff; thus concluding that "Torretti's circumstances are not those contemplated by EMTALA coverage."

As to the Torrettis' stabilization claim that defendants violated EMTALA because they did not stabilize her emergency condition and inappropriately transferred her, the appeals court concurred with the district court's dismissal of the claim on summary judgment because the Torrettis could not show that defendants had actual knowledge of an emergency medical condition, and "the requirement of actual knowledge is the key to this [EMTALA] issue." This court conformed with all its sister circuit courts of appeals that have addressed this issue under EMTALA and have determined that "Congress did not intend EMTALA to serve as a federal malpractice statute or cover cases of hospital negligence."

Case synopses prepared by Terri L. Nally, Principal, KAR Associates, Inc.