# Washington Watch

*by Kathleen Ream, Director of Government Affairs*

According to data obtained in the latest Drug Abuse Warning Network (DAWN) survey, out of the almost two million drug-related ED visits recorded in 2004, 1.3 million were associated with drug misuse or abuse. Of these 1.3 million visits, 30 percent involved illicit drugs only; 25 percent, prescription or over-the-counter medications only; 8 percent, alcohol only in patients under age 21; 15 percent involved illicit drugs and alcohol; 8 percent, illicit drugs and pharmaceuticals; and 14 percent, illicit drugs, pharmaceuticals, and alcohol. The findings are contained in a new report from the Department of Health and Human Services' Substance Abuse and Mental Health Services Administration (SAMHSA) entitled, ***Drug Abuse Warning Network, 2004: National Estimates of Drug-Related Emergency Department Visits***.

Due to changes from previous DAWN surveys – including an expanded definition of ED visits related to recent drug use, and a new sample of hospitals covering the entire United States – this latest survey is considered a new baseline for future years. As a consequence, the new data cannot be compared to data from prior years.

Based on data submitted by the 417 hospitals in its national sample, DAWN developed the following additional information:

- Cocaine was involved in 383,350 ED visits; marijuana in 215,665; heroin in 162,137; stimulants, including amphetamines and methamphetamine, in 102,843 visits. Other illicit drugs such as PCP, Ecstasy and GHB were involved with much less frequency.
- Non medical use of prescription and over-the-counter pharmaceuticals were involved in 495,732 ED visits. Over half (57%) of these non medical use visits involved more than one drug, and nearly a third (32%) involved opiates and opioid analgesics.
- The most frequently used prescription medications were benzodiazepines (144,385 visits), hydrocodon products (42,491 visits), oxycodone products (35,559 visits), and methadone (31,874 visits).
- Alcohol in combination with an illicit drug was involved in 363,641 ED visits by persons of all ages. In patients under the age of 21, alcohol alone was involved in 96,809 visits.

In commenting on the report, SAMSHA administrator Charles Curie said, "Most of the 1.3 million visits to emergency rooms involving drugs or alcohol misuse or abuse are an opportunity for the health care system to intervene and direct patients to appropriate follow-up care." The full report is available at **http://dawninfo.samhsa.gov**.

**EMTALA TAG Meets for Fourth Time**

Under the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003, the Secretary of Health and Human Services was mandated to establish a Technical Advisory Group (TAG) to review issues related to EMTALA and its implementation. The fourth meeting of the EMTALA TAG occurred on May 1 and 2, 2006. The primary purpose of the meeting was to enable the TAG to consider the work that its subcommittees had completed on specific issues tackled by the main group at previous meetings, as well as discuss the written responses received from various health care organizations regarding the same issues. Some topics that the TAG addressed and actions taken at this meeting included the following:

- Clarification that CMS does not require physicians to take emergency calls as a Condition of Participation in Medicare.
- Affirmation of the TAG recommendation that hospitals with specialized capabilities not be required to maintain EDs, but that these same hospitals still be bound by the same responsibilities under EMTALA as hospitals with specialized capabilities that do have a dedicated emergency department.
- Review of the proposed revisions to the EMTALA regulations and corresponding Interpretive Guidelines submitted by the Action Subcommittee on:
  (1) Emergency physician communication with other clinicians to seek advice regarding a patient's medical history and needs that may be relevant to the medical treatment and screening of the patient.
  (2) Definitions for "stabilization" and "emergency medical condition" as applied to psychiatric emergency patients and on transfer issues related to such patients.
  (3) When a hospital can discourage a non-hospital-owned ambulance from coming to the ED.
  (4) EMTALA compliance when an emergency is declared by a government authority at any level and the exceptions to compliance (e.g., massive equipment failure, bomb threat, snowstorm).
- Assessment of the proposed revisions to the Interpretive Guidelines submitted by the On-Call Subcommittee on hospital policies for:
  (1) Physician response times.
  (2) Availability of on-call physicians.

**EMTALA Claim Dismissed: Florida Hospital not Culpable for Patient's Criminal Conduct**

On summary judgment, the U.S. District Court for the Middle District of Florida threw out an EMTALA claim a man made arguing that he was coerced to leave a hospital where he had been taken for a drug overdose (Johnson v. Health Central Hospital, M.D. Fla., No. 6:04 cv 1436 Orl 31DAB, March 20, 2006).

The facts in this case involve the plaintiff Benjamin Levi Johnson, who overdosed on prescription medications and was taken to Health Central Hospital's ED where he underwent a medical screening examination and then was admitted to the intensive care unit. Johnson awoke and asked a nurse if he could make a phone call. He was informed that he could do so if he signed a form acknowledging that he was leaving the hospital against the advice of his physician and the hospital.

Johnson signed the form. The IVs were removed and Johnson was taken to a telephone in the hallway of the hospital where he called his boss to pick him up. Johnson left the hospital. Four hours later he assaulted a law enforcement officer, was convicted for that crime, and ended up serving 22 months in prison.

This case arose as Johnson sought to use the remedial provisions of the EMTALA to hold Health Central responsible for the consequence of his criminal conduct.

The hospital filed a motion for summary judgment. Such a motion by one of the parties to a suit contends that all necessary factual issues are settled or are so one sided that the facts need not be tried. In other words, the motion argues that no triable issue of fact exists and that the settled facts require an immediate judgment for the moving party.

The court wrote that the "undisputed facts reflect that Johnson received appropriate medical screening (under EMTALA), and was also the recipient of substantial efforts to stabilize his medical condition." The court noted that EMTALA provides a safeguard against patient dumping, not "a substitute for state law claims of medical negligence," – implying that a malpractice suit instead may have been pursued for allowing an intoxicated patient to sign out of treatment.

Nonetheless, the district court's Judge Gregory A. Presnell wrote in his ruling that Johnson's contention that "he was 'forced to

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leave the hospital by the nurse,' is patently ridiculous . . . only in America could someone make such an outlandish claim!"

**Tennessee Hospital Motion for Summary Judgment Denied in EMTALA Case**

On March 30, 2006, the U.S. District Court for the Western District of Tennessee found that genuine issues of material fact were set forth in a patient's lawsuit claiming that a Tennessee hospital was negligent and in violation of EMTALA when it failed to properly screen a suicidal patient and stabilize him prior to discharge from the emergency department. The court denied the hospital's motion to dismiss for summary judgment (Card v. Amisub (SFH) Inc., W.D. Tenn., No. 03-2528, 3/30/06).

Plaintiff Bruce Card arrived at the emergency department of Amisub (SFH) Inc., doing business at St. Francis Hospital in Memphis, Tennessee, "requesting medical care to avert danger of harm to himself due to depression, suicidal tendencies and substance and alcohol abuse." In the ED, Card described his symptoms to the admitting nurse, who then allegedly "performed a cursory medical examination/clinical evaluation" and gave Card a list of outpatient treatment centers to phone.

According to the complaint, Card called each of the centers, and was "refused treatment by each due to his health insurance status." He told the nurse that none of the centers would accept him for treatment. The nurse allegedly responded that "they had done all they could possibly do" for him.

Card then was discharged from the hospital, and subsequently began drinking and attempted suicide by cutting his wrist. He then was admitted to another emergency medical care facility where he received stitches and was involuntarily committed for treatment.

Card filed a lawsuit alleging that SFH failed to adequately screen him upon his arrival, failed to stabilize his condition prior to discharge and violated state and common law medical malpractice laws. SFH filed a motion requesting dismissal of the lawsuit, or in the alternative, summary judgment in its favor. The district court denied the motion.

Turning to the first claim of violating EMTALA by failing to properly screen the patient, the court stated that SFH initially moved to dismiss this claim because it was unsupported by expert testimony. The plaintiff then submitted an affidavit from a licensed physician contending that Card was not properly screened and "should have been evaluated beyond the clinical assessment stage of non-professional personnel."

SFH countered that the affidavit was insufficient to establish a genuine issue of material fact regarding proper screening, emphasizing that the physician's conclusions were based entirely on a review of the admitting nurse's deposition. The federal district court judge rejected the SFH argument, noting that critical evidence, such as the clinical assessment form and all other records pertaining to Card's visit to the hospital, was missing. Card had alleged that SFH destroyed the records after he filed the lawsuit. SFH did not refute the allegation.

The court also differed with SFH's line of reasoning that dismissal is justified on the grounds that Card's failure-to-stabilize claim was merely a state law negligence action. Rather, the court clarified that an action under EMTALA "is not analogous to a state medical malpractice claim because it creates liability for refusal to treat, which state malpractice law does not."

Liability under EMTALA also requires actual knowledge of the patient's emergency condition, which the court found based on a favorable disposition to Card's claim and the expert affidavits. Summary judgment on the failure-to-stabilize claim was inappropriate as Card had set forth a genuine issue of fact, the court held.

SFH's motion for summary judgment on the state and common law medical malpractice claim maintained that the plaintiff's submitted expert affidavits did not mention that SFH's actions caused Card's injuries. The court disagreed, writing that "this omission does not require the dismissal of Card's malpractice claim under the particular circumstances and procedural posture of this case." Owing to the alleged negligent loss or destruction of evidence by opposing party in a lawsuit, the court noted that plaintiff is unable to prove an essential element of his argument. In these circumstances, the federal court stated that it is proper for the trial court to create a rebuttable presumption establishing the incomplete elements of plaintiff's claim, which only could have been proved by the availability of the missing evidence.

Full text of the decision is available at **http://op.bna.com/hl.nsf/r?Open=thyd-6nsjt9**.

**Court Dismisses Inappropriate EMTALA Screening Claim**

On March 31, 2006, the U.S. District Court for the Eastern District of California dismissed three of Donna Hoffman's four complaints alleging that Kent Tonnemacher, an ED physician at Memorial Medical Center (MMC), in Fresno, CA, failed to provide her appropriate medical screening and stabilization, in violation of EMTALA (Hoffman v. Tonnemacher, E.D. Cal., No. CIV F 04-5714, 3/31/06).

The court also dismissed the plaintiff's issue of an inappropriate screening argued on disparate treatment in relation to six other patients treated by defendant Tonnemacher. At the same time, the district court rejected summary judgment to Tonnemacher and MMC on plaintiff's claim of disparate treatment based on the ED physician's failure to follow MMC's EMTALA policy, requiring a doctor to verify, or rule out, conditions that s/he suspects a patient may have.

The facts in this case begin when plaintiff arrived at MMC's ED on May 22, 2005. Tonnemacher examined and treated Hoffman, who complained of chills with hyperventilation, nasal congestion, cough, chest pain and numbness in her hands. Tonnemacher took a medical history, performed a physical examination, and ordered X-rays and a urinalysis. He diagnosed fever and bronchitis, with a differential diagnosis of possible pneumonia. He discharged her with a prescription for an antibiotic, reasoning that there may be potential concern for a bacterial illness.

Hours later, an ambulance returned plaintiff, to MMC's ED, in a septic condition. Hoffman's blood cultures were taken and examined, identifying a virulent streptococcus pneumonia bacterium. Plaintiff was admitted to MMC's ICU in critical condition. Hoffman survived the sepsis, but endured physical damage. She sued Tonnemacher and MMC for EMTALA violations and state law medical malpractice.

Expert physician witnesses for plaintiff contended that Hoffman's initial screening examination and emergency treatment were not up to applicable standards of care. The defendants countered that when Hoffman was discharged she was in stable condition, had an appropriate antibiotic prescription, and no additional medical screening or testing was indicated at that time.

The district court concurred with the defendants. Plaintiff's line of reasoning that the screening was not designed to detect an emergency medical condition and, thus was inappropriate, was aligned with the experts' testimony, which the court found were criticisms of negligence and not of EMTALA. Thus on this issue,

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the court granted MMC summary judgment, stating that "EMTALA is not a medical malpractice statute and does not establish a standard of care."

Hoffman's claim of inappropriate screening based on disparate treatment in relation to other patients treated by defendant, also was denied. The court found that Tonnemacher established different dispositive symptoms for other patients, so there could not be disparate treatment under EMTALA.

Plaintiff, who bore the burden of proof, could not persuade the district court of actual detection or knowledge in her stabilization claim. With the antibiotic prescription, an argument could be made that Tonnemacher did not rule out the presence of a bacterial process. Yet, the uncontroverted evidence demonstrated that the ED physician diagnosed a case of bronchitis, which typically is viral, and therefore believed that Hoffman was not suffering from an emergency condition at the time of discharge. Based on the diagnosis of bronchitis, for which plaintiff offered no testimony of instability, the federal district court granted summary judgment on the stabilization claim.

The court, however, did set a hearing date for one issue. It found that the defendant "did not rule out a bacterial process, even though a bacterial process was a concern . . . it is possible for a jury to conclude that Hoffman received disparate treatment in that Dr. Tonnemacher did not follow MMC's EMTALA policy."