AAEM Endorses "Save Medicare Act 2008"

Kathleen Ream,
Director of Government Affairs

In an April 22 letter from President Larry D. Weiss, AAEM endorsed S. 2785, the *Save Medicare Act of 2008*. Introduced by Senator Debbie Stabenow (D-MI) on March 13, 2008, S. 2785 would replace cuts totaling more than 15% with positive Medicare physician payment updates from July 1, 2008, through December 31, 2009. Stabenow's bill – with 17 cosponsors – is currently under consideration by the Senate Finance Committee.

In his letter, Dr. Weiss applauded Stabenow's leadership ". . . in introducing critical legislation that would protect patients' access to care by preserving the Medicare program and warding off steep pending cuts in physician payment rates that threaten access for our senior and disabled patients." He went on to say that "AAEM supports a permanent correction to the SGR that links physician payment to the real costs of healthcare."

Grants to Help Improve Access to Primary Care
The Centers for Medicare and Medicaid Services (CMS) recently awarded grants of $50 million to 20 states to help improve access to primary medical care so that Medicaid beneficiaries could avoid improper use of hospital EDs.

Created by the Deficit Reduction Act of 2005 (DRA), these grants will help Medicaid programs fund local and rural initiatives to provide alternative healthcare settings for individuals with non-emergent medical needs.

Grantees will use the funds to:
- Establish new community health centers;
- Extend the hours of operation at existing clinics;
- Educate beneficiaries about new services; and
- Provide for electronic health information exchange between facilities for better coordination of care.

States receiving grant funds under this program are Colorado, Connecticut, Georgia, Illinois, Indiana, Louisiana, Massachusetts, Maryland, Michigan, Missouri, New Jersey, North Carolina, North Dakota, Oklahoma, Pennsylvania, Rhode Island, South Dakota, Tennessee, Utah and Washington. These awards help align Medicaid efforts with Medicare's value-based purchasing strategies, also designed to avoid unnecessary ED visits through improved physician care and strategies to decrease re-admissions.

For more information on the grants, including the proposals and the amount each program will receive, go to http://www.cms.hhs.gov/GrantsAlternaNonEmergServ/

TN Medical Malpractice Bill Signed by Governor
Legislation aimed at preventing frivolous medical malpractice lawsuits in Tennessee – S.B. 2001 – was signed into law on May 15, 2008, by Governor Phil Bredesen (D). The measure, which becomes effective October 1, 2008, requires those asserting a medical negligence claim to provide a 60-day notice to providers against whom such allegations are made prior to filing a lawsuit. That notice would not apply to providers made party to the action after the filing of the complaint as a result of a defendant alleging comparative fault.

The new law also requires plaintiffs or their attorneys filing a medical malpractice claim requiring expert testimony to file a certificate of good faith within 90 days of the filing. Such certificates must state that a competent expert medical witness has been consulted and has provided a signed statement that expresses a professional belief that there is a good-faith basis to maintain the lawsuit. In addition, the measure requires the provision of "complete and unaltered copies" of the claimant's medical records within 30 days of receipt of a written request.

Both the Tennessee Medical Association (TMA) and the Tennessee Association for Justice (formerly the Tennessee Trial Lawyers Association) came out in support of the measure. "This legislation is an important step toward improving Tennessee's liability environment by addressing the significant problem of meritless lawsuits," said F. Michael Minch, Chairman of the TMA Board of Trustees. "By cutting down on the glut of lawsuits and the associated costs that clog our state's legal system, we will see a reduction in the cost of providing patient care and help Tennessee become a more attractive state to live and work for physicians in years to come." Daniel Clayton, President-elect of the Tennessee Association for Justice, stated that, "It will help eliminate, or at least significantly reduce the number of lawsuits which never should have been filed . . . although the bill is not perfect, it should accomplish its purpose."

EMTALA Round Up

Liability under EMTALA Ends at Admission
On March 24, 2008, the U.S. District Court for the Eastern District of Tennessee issued its decision determining that the potential liability under EMTALA "ends when a hospital admits in good faith a patient as an inpatient" (Anderson v. Kindred Hospital, E.D. Tenn., No. 1:05-cv-294, 3/24/08).

The Facts
Cora Cameron, now deceased, was admitted to Defendant Kindred Hospital for hemodialysis and rehabilitation. There was no dispute among the parties (i.e., Defendant and Cameron's daughters who are the Plaintiffs) that Cameron was relatively stable at admission. However, after 17 days as an inpatient, Cameron developed an emergent condition. After Kindred Hospital informed Plaintiffs that it was unable to perform dialysis on Cameron until the following day, "Plaintiffs . . . demanded that [Decedent] be taken by ambulance to Memorial Hospital for [immediate] stabilization and dialysis. An order for transportation was obtained," and Cameron was transported to the other facility. Plaintiffs filed a complaint against Kindred arguing that while EMTALA's screening and stabilization requirements apply to an "individual [who] . . . comes to a hospital," EMTALA's transfer regulation applies to all persons at the hospital, regardless of whether they have been admitted as

continued on page 10

Washington Watch - continued from page 8

inpatients. Defendant moved for summary judgment on the EMTALA claim, which is the motion discussed in this case.

The Ruling

To identify EMTALA's liability boundaries, this court examined the U.S. Congress's intent for EMTALA. It also examined the regulations, promulgated by the Department of Health and Human Services (DHHS) to implement EMTALA, that state that "[i]f the hospital admits the individual as an inpatient [in good faith] for further treatment, the hospital's obligation under [the EMTALA] ends . . ."

In light of the construction of the EMTALA statute, the court determined that Plaintiff's argument failed and found that EMTALA provisions "are to be read together, creating only a single duty on the part of the hospital to stabilize patients who have emergency medical conditions before they may be transferred." The court concluded that DHHS's regulation at issue "is fully compatible with the purpose, as well as the text, of the EMTALA . . . to prevent 'patient dumping,' . . . [and that] EMTALA "was not intended to guarantee proper diagnosis or to provide a federal remedy for misdiagnosis or medical negligence." Rather, the court affirmed that an EMTALA claim is not a substitute for a state law medical malpractice action. Thus, while the court granted Defendant's motion for summary judgment as to Plaintiffs' EMTALA claim, it declined to exercise jurisdiction over the remaining state-law claims.

To read the opinion, go to
http://op.bna.com/hl.nsf/r?Open=mapi-7d5pmh.

Sufficient Claim for Failure to Screen Allows Case to Proceed

On April 8, 2008, the U.S. District Court for the Eastern District of California issued an order refusing to dismiss a claim for failure to screen for an emergency medical condition under EMTALA. The order was based on the court's determination in its screening of the complaint that the claim of an EMTALA violation was sufficiently alleged (Tater-Alexander v. Amerjan, E.D. Cal., No. 1:08-cv-00372, 4/8/08).

The Plaintiff's Facts as Alleged

Plaintiff Michael Tater-Alexander alleged that he visited the Defendant Clovis Community Medical Center ED seeking emergency medical services for "great pain, extreme abdominal pressure and inability to eat or drink." Plaintiff alleged that his condition involving a pancreatic cyst that required draining was made known to Defendant. Tater-Alexander also alleged that performing blood tests and the eventual administering of an IV for draining the cyst, 10 to 12 hours after Plaintiff's presentation in the ED, contributed to Plaintiff's ultimately suffering physical and emotional injury, including permanent organ failure.

Plaintiff sought damages and injunctive relief claiming that Defendant's delayed treatment violated EMTALA's screening requirement that the examination must be comparable to that offered to other patients with similar symptoms. Tater-Alexander further contended that the delay in treatment constituted an "examination so cursory that it was not designed to identify acute and severe symptoms that alert a physician to the need for immediate medical attention to prevent serious bodily injury; the hospital failed to provide screening to diagnose an emergency medical condition."

To support this conclusion, Plaintiff alleged that Defendant hospital delayed because Tater-Alexander "refused staff requests to wear a hospital gown because he needed and wanted to remain warm in his sweat clothes due to a physical condition that caused extreme pain when he was cold." But Plaintiff also argued that "on that occasion and on two other occasions, Defendant hospital staff had no trouble checking his vitals or recording pain intensity while Plaintiff was wearing street clothes. Plaintiff then concluded that, "the requirement of wearing a hospital gown was only the personal preference of Defendants, that failure to wear a gown did not in any way hinder or prevent an appropriate screening and that Defendants intentionally failed to diagnose his condition."

The Ruling

Reviewing the EMTALA statute and case precedent, the federal court noted that evidence that a hospital did not follow its own screening procedures can support a finding of EMTALA liability for disparate treatment. So although many inferences were possible in the procedures for screening the claim, the court must resolve all doubts in the Plaintiff's favor. The court found that "Plaintiff stated a claim of refusal on the part of Defendants to screen as distinct from a voluntary refusal on Plaintiff's part to consent to treatment." The court then concluded that Plaintiff sufficiently stated a claim – of a failure to screen for an emergency medical condition by Defendant hospital pursuant to EMTALA – as a basis for jurisdiction in the federal court.

See the court's order at
http://op.bna.com/hl.nsf/r?Open=psts-7dlmr2.

No EMTALA Liability for Inadequacy in Screening Leading to Injury

The U.S. District Court for the Eastern District of California decided on April 10, 2008, to grant Defendant Memorial Medical Center (MMC) summary judgment on Plaintiff Donna Hoffman's EMTALA claims. Hoffman alleged injury caused by MMC's inadequate screening or by treatment she received, or by any departure from standard hospital screening protocols (Hoffman v. Tonnemacher, E.D. Cal., No. 1:04-cv-5714, 4/10/08).

The Facts

On May 22, 2003, Hoffman arrived at MMC's ED where she was examined by Dr. Kent Tonnemacher and diagnosed as having bronchitis with a differential diagnosis of pneumonia. Hoffman was discharged the same day with antibiotics because Tonnemacher had not been able to rule out a bacterial process. Less than 24 hours later, Hoffman returned to MMC in an ambulance and went into shock with systemic inflammatory

continued on page 12

Washington Watch - continued from page 10

response syndrome (SIRS). Hoffman was hospitalized for several weeks while suffering severe physical damage. A year later, Hoffman filed complaints against MMC and Tonnemacher for EMTALA violations and for California law medical malpractice.

Summary judgment was granted to MMC on two of Plaintiff's inadequate screening theories and on her failure to stabilize theory, but not on the complaint stemming from Tonnemacher's alleged failure to follow the hospital's EMTALA policy. The case then proceeded to trial, resulting in a mistrial. In post trial motions, and based on the Court's concerns regarding causation testimony at trial, MMC was allowed to file a second motion for summary judgment on the issue of causation.

In this second motion, MMC contended that summary judgment was appropriate because Plaintiff could not establish that her injuries were a direct result of an EMTALA violation. Plaintiff argued that the administration of certain tests (e.g., a CBC, blood sedimentation, CT scan, prophylactic intravenous antibiotics) would have allowed Tonnemacher to rule in a bacterial infection, leading him "to administer early goal directed therapy, which would have prevented SIRS and all sequelae from manifesting."

The Ruling

Referring first to the law, the court stated, "EMTALA imposes two duties on hospital emergency rooms: a duty to screen a patient for an emergency medical condition, and, once an emergency condition is found, a duty to stabilize the patient before transferring or discharging him." A hospital provides an "appropriate medical screening" when it conducts "an examination comparable to the one offered to other patients presenting similar symptoms."

Expert testimony had "created a triable issue of fact concerning MMC's EMTALA policy . . . [requiring] a physician to rule in or rule out an emergency medical condition." Experts testified that only a blood culture, for which results are slow-developing, could rule in the bacterial infection. Plaintiff countered with experts who stated that "an accepted way to treat early sepsis in the ED is to obtain blood cultures and, although the results are not available, start performing early intervention therapy or 'prophylactic therapy' or early goal directed therapy." The court noted that "administering prophylactic antibiotics or beginning early goal directed therapy prophylactically is not part of a medical screening, rather it is . . . protective treatment that is done before a condition is ruled in or ruled out." "The failure to provide prophylactic treatment is not a failure to screen or a disparate screening," wrote the court.

Since Tonnemacher did not diagnose sepsis, the court stated that "in following MMC's EMTALA policy, there needs to be testimony about which test results would have changed Dr. Tonnemacher's diagnosis from viral bronchitis to sepsis/bacterial infection in the bloodstream such that Dr. Tonnemacher would have then treated that condition with early goal directed therapy." A complicating factor crucial to the court decision was that Hoffman had a narrow 6-hour window in which early goal directed therapy may have been instituted before Hoffman's clinical course could have become inalterable. In this case, the 6-hour window to successfully commence early goal directed therapy began about the time Hoffman came to the ED on May 22. In its ruling, the district court referred to the final expert analysis that "of the screening tools available to Tonnemacher, none would have identified/ruled in or ruled out Hoffman's bacterial infection until after the 6 hour window for administering early goal directed therapy had expired."

Thus, the court found a failure of Plaintiff to prove causation, to the extent that "Tonnemacher's failure to rule in or rule out a bacterial infection as required by MMC's EMTALA policy during the May 22 presentation did not cause Hoffman harm." Summary judgment was appropriate, and although there were no EMTALA violations, the court suggested that state malpractice law may be implicated.

See the court's decision at http://op.bna.com/hl.nsf/r?Open=psts-7dsm6x.

Welcome to our newest 100% Residency Programs!

- Baystate Medical Center
- Louisiana State University – Baton Rouge
- Louisiana State University – Shreveport
- Johns Hopkins University
- St. Luke's Hospital-Bethlehem
- University of California San Francisco
- The Brooklyn Hospital Center

To sign your program up for 100% membership, please email info@aaemrsa.org