From the States . . .
California Reaches Settlement over 'Balance Billing'

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On May 24, California's Department of Managed Health Care (DMHC) reached a settlement with Prime Healthcare Services over the hospital system's practice of "balance billing." Under the settlement, Prime Healthcare will audit its billing records from the last six years and provide refunds with interest to patients who paid balance bills. They will also donate $1.2 million to six community clinics in California. Cindy Ehnes, director of DMHC, said it is unclear how many patients will receive reimbursements or how much Prime Healthcare will need to pay. She said state regulators would pressure the hospital system to deliver the refunds as soon as possible.

Florida Sovereign Immunity Bill Dies in Committee

Legislation that would have limited the liability of doctors, nurses and EMS personnel for ED errors – even in cases of gross negligence – died in the Florida Senate Committee on Banking and Insurance on April 30. The Florida Medical Association and the Florida Hospital Association backed the bill.

SB 1474, sponsored by Senator John Thrasher (R), would have extended what is known as "sovereign immunity" to hospital EDs – giving emergency health care providers the same protection from liability lawsuits as public employees and institutions. The bill would have capped damages from lawsuit awards at $200,000 per incident, with the state government – not the doctors involved – defending malpractice cases arising from the state's 205 EDs. If juries gave an award in excess of the $200,000 cap, the state would have assumed the liability. In those cases, however, since the state has sovereign immunity from such lawsuits, plaintiffs would have had to file a so-called "claims bill" in the legislature to get the money.

Florida lawmakers have proposed similar measures extending sovereign immunity to EDs the past three years. Support for and opposition to SB 1474 is not divided along party lines. In agreement with Thrasher's position that the threat of lawsuits is a driving factor behind the shortage of doctors willing to staff EDs, Senator Eleanor Sobel (D) supported the bill. On the other hand, Senator Dennis Jones (R) joined Senate Minority Leader Al Lawson (D) in opposition.

The state's public hospitals already have sovereign immunity protections in lawsuits. After a debate about medical malpractice in 2003, the legislature passed a law that includes some liability protections for ED doctors (e.g., limits on non-economic damages compensating victims for pain and suffering of $150,000 or $300,000, depending on the circumstances). However, in extending the sovereign-immunity limits to EDs at all hospitals that provide emergency care and to all ED workers, SB 1474 goes much further. Debra Henley, a lobbyist for the Florida Justice Association, a trial lawyers group, said, "The scope of this bill is massive." Citing a similar view, Lawson called the measure "just too broad."

District Court Allows EMTALA Screening Claim of Excessive Delay in Treatment

On February 5, 2010, the U.S. District Court for the Eastern District of Pennsylvania held that a patient's screening claim under EMTALA could proceed based on the alleged lengthy delay between the time the patient arrived in the ED with chest pains, and the time he allegedly was examined by a doctor and treated for those chest pains (Byrne v. Cleveland Clinic, E.D. Pa., No. 09-889, 2/5/10).

The Facts

William Byrne arrived at the Chester County Hospital (CCH) ED – an affiliate of Cleveland Clinic – at 5:00 p.m. on February 15, 2007, complaining to the ED staff of severe chest pain and shortness of breath. Approximately 20 minutes after his arrival, blood was drawn from Byrne and an EKG was ordered. About 30 minutes later, a chest x-ray was performed. During this period, no physician was in attendance, no oxygen was provided, nor were "clot busting" drugs administered, nor was his heart monitored. Byrne alleges that it took two hours after his arrival for an ED physician to attend to him and to provide Byrne with a choice between a "clot busting" drug or a stent, the latter which was recommended by the physician.

A catheterization procedure was performed on Byrne, and he came out of this procedure at approximately 11:30 p.m. The court record indicated that it was "unclear what the catheterization procedure entailed, and who performed the procedure." Byrne claimed that, owing to the delay in receiving treatment, his heart was damaged and he suffered mental duress.

Byrne filed suit against CCH and Cleveland Clinic maintaining that the ED's delay in treating him was a violation of EMTALA's screening and stabilization provisions. He also alleged that CCH breached an implied contract, under Pennsylvania law, to treat him within 90 minutes of his arrival at the ED. Defendants moved to dismiss the complaints.

The Ruling

The federal court denied the defendants' motion to dismiss Byrne's EMTALA screening claim. The court wrote that "the jury could rationally conclude, absent any explanation or mitigating circumstances, that the Hospital's inaction here amounted to a deliberate denial of screening . . . Similar reasoning has been applied by other courts in cases where plaintiffs alleged that lengthy emergency room delays gave rise to an EMTALA screening claim."

The defendants pointed out that CCH's obligation under EMTALA's screening position was satisfied via the various tests and a catheterization procedure that eventually were performed on Byrne. The court responded noting that the provision of "some testing or treatment to a patient [does not] a *priori* satisfy a hospital's statutory obligation to appropriately screen . . . Based on the case law, as well as common sense, chest pains certainly may constitute an 'immediate and acute threat to life'."

Under the pleading standard for an EMTALA screening claim, claimant "need only allege that . . . a hospital's emergency room failed to screen the plaintiff or did not apply the same standard of screening to the plaintiff that it applies to other patients." The court held that while Byrne's allegations are liberally construed, as he represented himself in this case without benefit of an attorney, the claims reflect that CCH "failed to provide him with an 'appropriate' screening examination, as shown by the alleged lengthy delay between the time Mr. Byrne arrived in the emergency room with chest pains, and the time he allegedly was eventually examined by a doctor and treated for those chest pains."

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The court added that the decision should not be construed "to suggest that an EMTALA screening claim can arise from every delay that occurs after a patient arrives in a hospital emergency room… At this juncture in the life of this case, it is not clear whether Mr. Byrne's EMTALA screening claim will survive the summary judgment stage (should a defendant choose to pursue such a motion after discovery), but the allegations . . . are at least minimally sufficient to survive a motion to dismiss."

The motion was granted for the defendants to dismiss the plaintiff's EMTALA stabilization claim, "[C]aselaw makes it clear," wrote the court, "that EMTALA mandates stabilization only in the event of a transfer or discharge, and does not obligate hospitals to provide stabilization treatment for patients who are not transferred or discharged." Since Byrne was not transferred or discharged from CCH prior to receiving a catheterization procedure and being stabilized, the court determined that Byrne could not bring a stabilization claim under EMTALA. "[A]lthough a hospital's egregious delay in providing screening may provide the basis for an EMTALA screening claim, it does not provide a basis for an EMTALA stabilization claim."

The court also granted the defendants' motion to dismiss Byrne's state law breach of implied contract claim. Under Pennsylvania law, the court concluded that "Mr. Byrne cannot proceed with a claim for breach of implied contract on the facts alleged, where his contract claim is based on an alleged delay in treatment, and not the treatment or specific result itself." That is, a breach of contract claim against a health care provider only is permitted when the parties have contracted for a specific result.

To read the decision, go to: http://www.paed.uscourts.gov/documents/opinions/10D0137P.pdf

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In some specialties, such as family medicine, patients have some degree of freedom in choosing which provider they will see. In emergency departments, however, patients have less freedom in this regard. They select only the location, and then a caregiver is assigned to them. When a caregiver introduces themselves as a "doctor", most patients assume they are being cared for by a physician. One can envision a point in the future where emergency department patients will be cared for by a multitude of doctors simultaneously: attending physician, doctor of nursing practice, doctor of respiratory therapy, doctor of social work, et cetera. This certainly could cause confusion for patients in figuring out who is in charge of their care. Opinions may vary among all of these doctors, adding to a patient's confusion: "One doctor told me this, but another said something different. Who should I listen to?" Patients deserve to have a good understanding of the qualifications of anyone providing a medical opinion.

The point of this article is not to imply that everyone with a doctorate wants to give the impression that he or she is a physician. However, the confusion that this creates for some patients is real. Anyone who has masters-level nurse practitioners in their department can attest to the confusion that already exists among some patients about their caregiver's credentials. In a 2009 blog, an editor of the journal "Advance for Nurse Practitioners" reported that a pending survey at the time showed 33% of NP's would use the title 'doctor' if they had a doctoral degree.[5] This suggests that this issue is going to become much more prominent over the next few years.

Nothing in this column should be construed as minimizing the value of nurse practitioners and other providers with advanced degrees. In fact, nurse practitioners fulfill an important role in helping to provide care where physician shortages exist. In an ideal world, every emergency department would be staffed with board-certified emergency physicians. Currently, however, there just are not enough of us to meet the existing need. When used appropriately in the ED, nurse practitioners can provide much needed coverage in busy emergency departments unable to provide adequate physician coverage. Patients, though, deserve to know the qualifications of the persons providing their treatment. In the clinical environment, patients usually equate "doctor" with "physician". Providers describing themselves as a doctor must ensure that their credentials are correctly represented.

(Endnotes)

1 "Frequently Asked Questions, Position Statement on the Practice Doctorate in Nursing." American Association of Colleges of Nursing Website. American Association of Colleges of Nursing, March 2010. Accessed July 28, 2010. <http://www.aacn.nche.edu/DNP/dnpfaq.htm>.

2 "AANA Announces Support of Doctorate for Entry into Nurse Anesthesia Practice by 2025." American Association of Nurse Anesthetists Website. American Association of Nurse Anesthetists, September 20, 2007. Accessed July 28, 2010. <http://www.aana.com/news.aspx?id=9678>.

3 "Fact Sheet: The Doctor of Nursing Practice (DNP)." American Association of Colleges of Nursing Website. American Association of Colleges of Nursing, March 2010. Accessed July 28, 2010. <http://www.aacn.nche.edu/Media/FactSheets/dnp.htm>.

4 "Doctor of Nursing Practice (Amherst)." UMassOnline. University of Massachusetts, March 5, 2010. Accessed July 28, 2010. <http://www.umassonline.net/degrees/Online-Doctor-Nursing-Practice.cfm>.

5 Ford, Jennifer. "PA Says DNPs Shouldn't Be Called 'Doctor'" AdvanceWeb. Merion Matters, Inc., February10, 2009. Accessed July 28, 2010. <http://community.advanceweb.com/blogs/np_1/archive/2009/02/10/pa-blogs-about-the-dnp.aspx>.

CONGRATULATIONS *to*

Mark T. Steele, MD FAAEM

who has assumed the office of
President of the
American Board of Emergency Medicine
(ABEM).