

LEGAL ALERT

April 16, 2009

RECENT COURT DECISION ON EMTALA IS PROBLEMATIC FOR HOSPITALS

By Maria T. Saez and Veronica A. Marsich, Attorneys

Do EMTALA's requirements extend beyond the emergency department? Does a hospital's obligations under EMTALA end when a patient presenting to the emergency department is admitted to the hospital as an inpatient? Until this week, most health law experts would have answered "yes" to both of these questions. But in the recent case of *Moses v. Providence Hospital*, the 6th Circuit Court of Appeals says "no" and, in doing so, adds quite a bit of ambiguity to EMTALA compliance efforts.

EMTALA's (Emergency Medical Treatment and Active Labor Act) is a federal statute that imposes specific obligations on Medicare-participating hospitals that offer emergency services to provide a medical screening examination (MSE) when a request is made for examination or treatment for an emergency medical condition (EMC), including active labor, regardless of an individual's ability to pay. Hospitals are then required to provide stabilizing treatment for patients with EMCs. If a hospital is unable to stabilize a patient within its capability, or if the patient requests a transfer, an appropriate transfer should be implemented.

In *Moses*, the plaintiff was the estate of Marie Moses Irons, whose husband was taken to the emergency

department of Providence Hospital with various physical symptoms such as high blood pressure and severe headaches, as well as slurred speech, disorientation, hallucinations and delusions. He had also demonstrated threatening behavior towards his wife. The patient was evaluated by hospital staff and admitted as an inpatient for further testing and treatment. After approximately six days, the patient was deemed stable and discharged. Ten days later, the patient murdered his wife.

The first issue considered by the Court was whether a non-patient has standing to sue under EMTALA.

This holding is troubling because it is contrary to the legislative history of the statute and the intent of the statute as a whole.

The Court found that the plain language of the statute (namely that "any individual" who suffers harm due to a hospital's violation of EMTALA may bring suit) clearly allowed for standing by a non-patient. This holding is troubling because it is contrary to the legislative

history of the statute and the intent of the statute as a whole.

Also troubling is the Court's decision that a hospital's obligations under EMTALA does not end upon inpatient admission of the patient. The Court, by ignoring CMS guidance on this issue stating that admitting an individual as an inpatient satisfies the hospital's EMTALA's obligations, held that a hospital's decision to admit a patient for further

testing does not satisfy EMTALA's requirement that the hospital treat the patient so as to stabilize him. The Court disregarded the CMS guidance as "contrary to EMTALA's plain language" and as not having any retroactive effect on this case since the patient's stay ended prior to the regulation's creation. The Court held that EMTALA forbids a patient's release unless his condition is stabilized to the point where no further deterioration of the condition is likely. Therefore, because EMTALA requires a hospital to treat the patient to stabilize the condition, simply admitting a patient is not enough. As the Court stated, EMTALA "requires more than the admission and further testing of a patient; it requires that actual care, or treatment, be provided as well."

The lower court in *Moses*, like many courts in other circuits, found that EMTALA is not intended to be a federal malpractice statute and that under EMTALA, a court should only be concerned with whether the patient was diagnosed with an emergency medical condition and whether he was discharged when he was not stable. EMTALA does not guarantee that a hospital will correctly diagnose a patient's condition. Interpreting EMTALA to require stabilization treatment after diagnosis of an EMC and during an inpatient admission raises questions not answered by Congress such as when the duty to treat terminates, for how long treatment must be provided and when a temporal delay in treatment constitutes a violation of the duty to provide stabilization treatment. To require this would make EMTALA a malpractice statute. The lower court believed that issues about how well a patient is treated are dealt with under state malpractice law, not EMTALA.

Given these prior EMTALA holdings, it is difficult to understand how the 6th Circuit could have gotten it so wrong. One explanation is that the Court's decision is less "wrong" than it is poorly drafted. In reading the opinion, it seems that the Court had serious doubts as to whether the hospital and the physicians really discharged the patient because they thought he was stable or because his insurance had

denied coverage for the care he might have required. Questions of fact on these issues would have justified denying the hospital's motion for summary disposition. Unfortunately, instead of directly challenging the veracity of the hospital's position, the Court published an opinion which leaves hospitals and future courts in this jurisdiction with a terribly confusing opinion and considerable risk when treating the next patient admitted through the emergency department who is determined stable for discharge. The Court could have reached such a conclusion without disregarding CMS regulations and without taking a position contrary to all other circuits.

Unless and until *Moses* is overturned or reconsidered, the lessons to be learned might come down to these:

- Clearly document whether the patient is found to have an emergency medical condition.
- Clearly document when the patient is found to be "stable" and what clinical observations led to that conclusion.
- Where recommendations for treatment are made and ultimately not followed, document the reasons why the recommendations were not followed.
- Where inconsistencies exist in a medical record regarding a patient's stability for discharge or need for further inpatient services, resolve those inconsistencies BEFORE discharging the patient.
- In the 6th Circuit... don't take anything for granted!

Maria practices in the area of health law and employment law. She can be reached directly at 734.913.5517 or msaez@shrr.com.

Veronica represents leading hospitals, health care providers and physician groups of all types in health law related transactional and regulatory matters. She can be reached directly at 734.913.6662 or vmarsich@shrr.com.