Obstetrics & EMTALA

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In 1985, the United States Congress passed the Emergency Medical Treatment and Active Labor Act (EMTALA) to govern a hospital's administration of emergency care. EMTALA expressly grants every individual a level of treatment that he or she should receive while in a hospital's emergency care, regardless of that individual's insurance coverage, ethnicity, or even citizenship. The EMTALA is often referred to as the "Anti-Dumping Law" or "Patient Transfer Act" and was originally intended by the 99th Congress to prevent private hospitals from transferring or discharging unstable and/or indigent patients to public hospitals (1). If a hospital accepts Medicare payment, it has voluntarily agreed to adhere to the regulations set forth by the EMTALA. Consequently, the EMTALA governs 98% of all hospitals in the United States and U.S. territories (2).

EMTALA requires that if any individual presents to the emergency department of a Medicare-accepting hospital and requests an examination or treatment, the hospital must provide an appropriate screening to determine whether the patient has an emergency medical condition (3). An appropriate medical screening examination is a screening to determine the existence of an emergency medical condition that is the same or similar to the screening provided to all patients presenting to the emergency department or emergency room complaining of the same condition or exhibiting the same symptoms or condition (4).

The EMTALA defines the term Aemergency medical condition as acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in either placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment of a bodily function, or serious dysfunction of any bodily organ or part. One could also define an "emergency medical condition" as, with respect to a pregnant woman who is having contractions, a situation where there is inadequate time to effect a safe transfer to another hospital before delivery, or where the transfer may pose a threat to the health or safety of the woman or the unborn child (5).

If the treating facility determines that the patient suffers from an emergency medical condition, the hospital must provide either, further medical examination and treatment as may be required to stabilize the patient=s condition, or transfer the individual to another medical facility so long as the transferring hospital stabilizes the individual's condition prior to transfer (6).

One can consider an individual to be "stabilized" when there is either no likely material deterioration of the condition, within reasonable medical probability to result from or occur during the transfer of the individual from a facility, or with respect to an emergency medical condition of a pregnant woman who is having contractions, that the woman has delivered the child and the placenta (7).

In order to bring an EMTALA claim alleging a transfer violation under the stabilization provisions, plaintiff must show that the transferred patient was not stabilized and that the doctor was negligent in transferring the patient in the sense that, under the circumstances, the physician knew or should have known that the benefits of transfer did not outweigh the risks (8). In determining whether a

transferring hospital has stabilized the patient within the meaning of the EMTALA, the jury must consider whether the treatment was reasonable in view of the circumstances that existed at the time the hospital transferred the patient (9).

If a hospital transfers a patient in order to obtain a higher-level of care that is necessary given the patient's condition, because that level of care is not available at the transferring hospital, then the transferring emergency physician must certify that the benefits of the transfer outweigh the risks of the transfer. The emergency physician must also obtain patient's informed consent and arrange that an "appropriate transfer" take place.

Transfer certification must be in writing, per the EMTALA, and must include the following language: "Based on the information available to me at the time of this transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risk to the individual and, in the case of labor, to unborn child from effecting the transfer." (10) "The certifying physician must include a summary of the risks and benefits upon which such certification is based." (11) If the certifying physician fails to include all of the available risks, then one cannot consider the patient to have informed consent, and consequently, the transfer would violate the EMTALA.

An "appropriate transfer" of an unstable patient, whether it is medically driven or patient requested, must meet all of the following five elements in order to adhere to the EMTALA requirements (12): First, the hospital that is transferring the patient must provide emergency medical care to decrease the risks to the patient and the unborn child. The hospital must do everything it is capable of doing to stabilize the patient prior to transfer. Second, the hospital that is receiving the transferred patient must have the space available and must have agreed to accept that patient. Additionally, the hospital that is receiving the patient must have the facilities and/or staff in order to treat the patient adequately. Third, the transferring hospital must send the receiving hospital all the patient's pertinent medical records, name, and address, but not in any fashion that would delay the physical transfer of the patient. Fourth, qualified personnel must perform the transfer and provide equipment in order to be able to administer appropriate medical care at any time while the patient is in route. Fifth, the transfer must adhere to the regulations set forth by the United States Secretary of Health and Human Services.

A hospital can transfer a pregnant mother if she requests transfer to another medical facility, after first being informed of the hospital's obligations under the EMTALA and of the risk of transfer. A hospital can also transfer a patient if a physician has signed a certification that based upon the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual and, in the case of labor, to the unborn child from effecting the transfer (13). The transferring hospital's physician must make a reasonable determination, based on the patient's emergency medical condition that the transfer is in the best interest of both the mother and the unborn child (14).

Pursuant to the EMTALA, the only method of stabilizing pregnant patient with contractions is delivery (15). Not all pregnant women having contractions are in "active labor" such that their transfer would be in violation of the EMTALA. Under the statute, a hospital cannot transfer a pregnant woman if, within a reasonable medical probability, she will deliver her child before the completion of a safe transfer or if she or the child is in imminent danger of death or serious

disability. Even though contractions alone do not equate to "active labor," plaintiff's condition represented a risk of potential deterioration of her and her child's health, which the EMTALA defines as an emergency medical condition (16).

Essentially, there are four ways that a transferring hospital can violate the certification provision of the EMTALA. First, before transfer, the hospital must have the attending physician sign the required certification. Second, since the statute requires more than just a signature, but certification, the transferring hospital violates the EMTALA if the treating physician did not actually deliberate and weigh the medical risks and benefits of transferring the patient, before the treating physician signed the certification. Third, if the physician makes an improper consideration a significant factor in his or her decision, then the transferring hospital would have violated the EMTALA (17). Fourth, a transferring hospital would be in violation of the EMTALA if the physician that executes the certification actually concludes that the risks of transferring outweigh the benefits, but certifies that the opposite is true (18).

In a recently litigated obstetrical case, the plaintiff, a pregnant female at 34 weeks gestation alleged that the defendant, a small community hospital in rural Iowa breached not only the standard of care but also violated EMTALA by transferring her to a hospital over a hundred miles away. Unfortunately although a prompt cesarean section was performed at the transferee hospital, the baby was delivered stillborn. The Defendant doctor reasoned that the Plaintiff had received her pre-natal care at the transferee hospital and that they were better equipped to handle a 34-week newborn. Inasmuch as they had a Neonatal Intensive Care Unit. Plaintiff countered, arguing that by virtue of her two previous cesarean sections, as well as her premature rupture of membranes, bleeding and pain, as well as a non-reactive fetal heart rate monitor, the mother and baby were unstable and thus not candidates for transfer. Plaintiff argued that an emergency cesarean section was indicated and that in the event that the baby needed the services of a Neonatal Intensive Care Unit, the baby could be stabilized at the delivering hospital and later transferred.

The medical records established that the defendant's emergency room physician recognized that the plaintiff had an emergency medical condition. Simply put, plaintiff's emergency medical condition was active labor as demonstrated by her contractions, dilation, and effacement. Although the records indicated that defendant doctor stated, "Within a reasonable degree of medical certainty, no material deterioration of the patient's emergency medical condition is likely to result from or occur during transfer." This is not alone sufficient to establish that the transferring hospital stabilized the patient within the meaning of the EMTALA.

At the time her transfer, the plaintiff was in labor. She was contracting, dilated two centimeters, and was fifty percent effaced. She had a history of two previous cesarean sections and as such, was at risk of uterine rupture. She had a reported history of significant vaginal bleeding just prior to presenting to defendant emergency department. She was experiencing and reporting significant abdominal pain between contractions. An abdominal ultrasound interpreted by the ultrasound technician and the emergency room physician showed abnormalities that could have been indicative of a placental abruption. Notwithstanding the vaginal bleeding, which the emergency physician observed and noted, the hospital transferred the pregnant patient. Plaintiff's experts testified that the Defendant hospital did not stabilize the plaintiff prior to transfer as she was still in labor, had signs of placental abruption, had vaginal bleeding, abdominal pain, was at high risk for a uterine rupture.

Defendant hospital asserted that the court should absolve it of any claims of the EMTALA violations

because plaintiff consented to the transfer. However, the existence of the consent form in and of itself does not defeat an EMTALA claim. In a failure-to-stabilize case, even though patients can sign an informed consent with respect to the transfer, it is a question of fact for a jury as to whether the hospital transferred the patient in violation of the EMTALA(19). To interpret the EMTALA in such a mechanical way, where the presence of a form relinquishes all of the transferring hospitals' liability, would contradict the entire purpose of the statute.

In a certification defense, the transferring hospital argued that it was not liable for transferring the patient without stabilizing her and her child's known emergency medical condition, because the transferring hospital informed plaintiff of its duties under the EMTALA statute and immediately thereafter obtained the patient's written consent. In addition, the hospital completed a certificate indicating that the reasonably expected medical benefits of the transfer would outweigh the increased risks to the patient, which was included in the patient's written transfer consent form.

Plaintiff contended that the defendant hospital's "consent to transfer" form was far too deficient. The "foreseeable risks" of which the pregnant patient was informed of, included only the continuation of the symptoms she was already experiencing, more bleeding and painful contractions. The transfer consent form failed to indicate that the hospital advised the patient of her risk of hemorrhage, uterine rupture, and both maternal and fetal demise. The defendant emergency physician could not have reasonably believed that the risks of transfer outweighed the benefits. The patient was at 34½ weeks gestation and the risk associated with prematurity at this stage is minimal. The transfer involved transporting by ambulance, over 100 miles, a patient who was in labor, who was bleeding vaginally, who was having painful contractions, and who was at risk for a uterine rupture in light of her two prior cesarean sections. Even worse, the fetal heart monitor was non-reactive. Plaintiff's experts testified that deterioration of the baby's condition was not only foreseeable, it was in fact likely. In point of fact, the fetal monitor did markedly deteriorate en route with persistent late decelerations and loss of variability.

The fact that the defendant emergency physician executed the certification form indicating that the benefits of treatment outweighed the risks of transfer does not, in and of itself, resolve the issue. The courts have historically recognized that the question is whether the transferring physician knew or reasonably should have known that the benefits of transfer did not outweigh the risks (20).

The jury found not only that the Defendant doctor and hospital were negligent, but also that the Defendant hospital violated EMTALA inasmuch as they found that the patient had an emergency medical condition that was not adequately stabilized and it was reasonably foreseeable that the condition of the mother and/or baby could deteriorate en route. The jury further found that the Defendant hospital failed to establish its certification defense. The jury award $1,700,000.00 in damages for loss of society and companionship.

In conclusion, any person who has been harmed by a transfer that violated the EMTALA may sue the transferring hospital for damages under that state's laws regarding personal injury and medical malpractice (21). Though state substantive laws regarding damages would govern such a claim, the federal expert witness rules would apply due to the federal preemption of procedural laws. A claim filed under EMTALA would preempt any state's notice provisions, discovery limitations, review panels, mandatory arbitration, statute of limitations, and potential immunity defenses (22). Notwithstanding the defendant's right to remove the claim to federal court (23), plaintiffs have the choice to either sue in federal or state court, whichever is more beneficial to their cause.

Consequently, plaintiffs may be able to bypass state tort reform acts and medical malpractice procedural obstacles by filing their EMTALA claim in federal court.

In appropriate cases, Plaintiff's counsel should consider EMTALA claims in addition to malpractice claims. Like many others, this author has found the principles set forth in Rules of the Road by AAJ members Rick Friedman & Patrick Malone to be most useful in medical malpractice trials. What better source for a "rule" than a federal statute? The jury can be told that this issue is so important that the United States Congress felt compelled to pass a law to condemn this type of medical practice. This is a strong message that should resonate with any fair-minded juror.

Footnotes:
(1) HR Rep No. 241 I, 99th Cong, 1st Sess 27 (1986).
(2) 42 USC §1395dd
(3) 42 USC '1395dd(a).
(4) 3C Fed. Jury Prac. & Instr. § 176.30 (5th ed.)
(5) 42 USC ' 1395dd (e)(1).
(6) 42 USC ' 1395dd(b)(1).
(7) 42 USC '1395dd(e)(3)(B).
(8) Cherkuri v Shalala, 175 F. 3d 446, 450 (6th Cir. 1999).
(9) Delaney v Cade, 986 F.2d 387, 393 (10th Cir. 1993).
(10) 42 USC 1395dd(c)(1)(A)(ii).
(11) 42 USC 1395dd(c)(1)(B).
(12) 42 USC § 1395dd(c)(2).
(13) 42 USC § 1395dd(c)(1)(A)(i) and (ii).
(14) Cherkuri v Shalala, 175 F.3d 446, 450 (6th Cir. 1999).
(15) 42 USC § 1395dd(e)(3)(B).
(16) 42 USC § 1395dd(e)(1).
(17) 42 USC § 1395dd(c)(1)(A)(ii).
(18) Burditt v. United States Department of Health and Human Services, 934 F.2d 1362, 1371-72 (5th Cir. 1991).
(19) Malave Sastre v Hospital Doctor's Center, Inc. 93 F. Supp. 2d 105, 110-111 (D.P.R. 2000),
(20) Cherkuri v Shalala, 175 F.3d 446, 450 (6th Cir. 1999).
(21) 42 USC § 1395dd(d)(2)(A)
(22) Power v Arlington Hospital, 42 F.3d 851 (4th Cir. 1994).
(23) 28 USC § 1441(b)