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100th Case Law Article

Journal

of healthcare risk management

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As the world adjusts to the rapidly evolving COVID-19 circumstances, we all find ourselves in uncharted territory. ASHRM, like many others, continues implementing resources necessary to ensure the safety of our members and community. To that end, ASHRM would like to take a moment to thank you for all that you are doing today to support and protect your community, health care organizations and loved ones. Your hard work has not gone unappreciated nor unnoticed. ASHRM is supporting you while your focus is on others. Thank you!



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About ASHRM

The American Society for Health Care Risk Management (ASHRM) is a personal membership group of the American Hospital Association with members representing health care, insurance, law, and other related professions.

ASHRM promotes effective and innovative risk management strategies and professional leadership through education, recognition, advocacy, publications, networking, and interactions with leading health care organizations and government agencies.

ASHRM initiatives focus on developing and implementing safe and effective patient care practices, the preservation of financial resources, and the maintenance of safe working environments.

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The mission of the *Journal of Healthcare Risk Management* is to advance the field by publishing research and analysis that drives improvement in both the literature and practice of health care risk management.

About the Journal

The purpose of the *Journal* is to publish research, trends, and new developments in the field of health care risk management. Articles also are archived for ASHRM members at www.ashrm.org.

The society invites individuals to submit manuscripts to be considered for publication. Topic areas include (but are not limited to) quality assurance, professional liability claims management, loss prevention, patient safety, risk management program development, and risk management-related legislation and legal issues.

Original manuscripts must be submitted exclusively to the *Journal of Healthcare Risk Management*. All material submitted to the *Journal* is subject to review by the Editorial Review Board. A copy of the complete editorial policy is available upon request from the society and at www.ashrm.org (About ASHRM, FAQs). Those manuscripts accepted for publication will be edited. Authors should include with each article a brief biographical statement that includes title, area of specialization, and current affiliation.

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Executive Director's Letter

ASHRM recognizes John West contributions



**Matthew B.
Homberger,
MBA, CAE**

This journal edition is dedicated to the importance of case law and the application to risk management. It is also our honor to recognize the contributions of author John West in this issue.

My favorite article in this edition is Sue Boisvert's candid interview with John; he speaks about the honor bestowed on him to write case law years ago and his surprise that this is his 100th edition of Case Law Update. This is typical of John's very modest nature, and I hope his readers will join me in thanking him for his important contributions to the field.

You will also find useful information to assist in their daily risk management practice, such as the article written by Chris Allman, which explains the importance of case law and what it means to risk managers. I think that you will also enjoy articles written by Dan Groszkruger, a frequent ASHRM contributor, and Bob Bitterman, who examines EMTALA issues through the lens of Case Law Update.

It is with great pleasure as executive director of ASHRM to share the 100th publication of Case Law Update. Enjoy!

A handwritten signature in black ink, appearing to read 'M. Homberger', with a long horizontal flourish extending to the right.

Executive Director, *Journal of Healthcare Risk Management*

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President's Message

Case Law provides a road map



**Hala Helm, MBA,
JD, CHC, CPHRM,
DFASHRM**

Greetings,

This issue of the ASHRM *Journal of Healthcare Risk Management* is dedicated to case law, and the 100th case law update by our esteemed friend and colleague, John West. As risk professionals, we spend much of our working lives trying to answer hypothetical questions on potential risks, probable risks, and how to mitigate these risks that have not yet materialized. Case law provides us with a roadmap—we can learn through the power of storytelling exactly what risks have emerged for our fellow organizations, how they succeeded or failed in mitigating those risks, and what the ultimate outcomes were. We can use those lessons learned to compare or distinguish the risks presented in our own organization and shape our responses accordingly.

Case law can inform our thinking and provide persuasive, tangible support for the position we ultimately advocate. It can also, at times, be highly entertaining, especially in the capable hands of John West. I hope you all enjoy reading as much as I will.

A handwritten signature in black ink, appearing to read 'Hala Helm'.

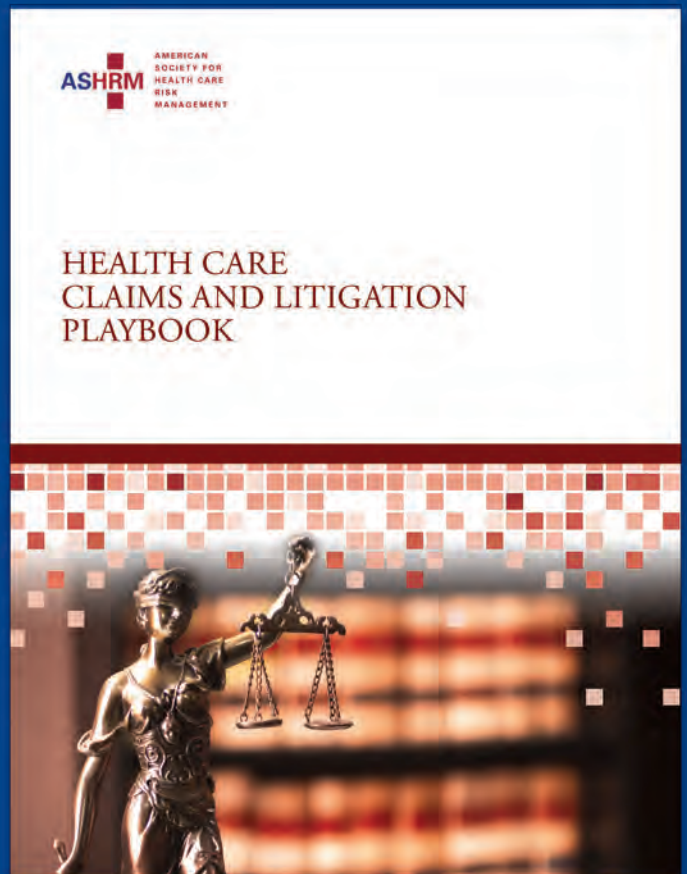
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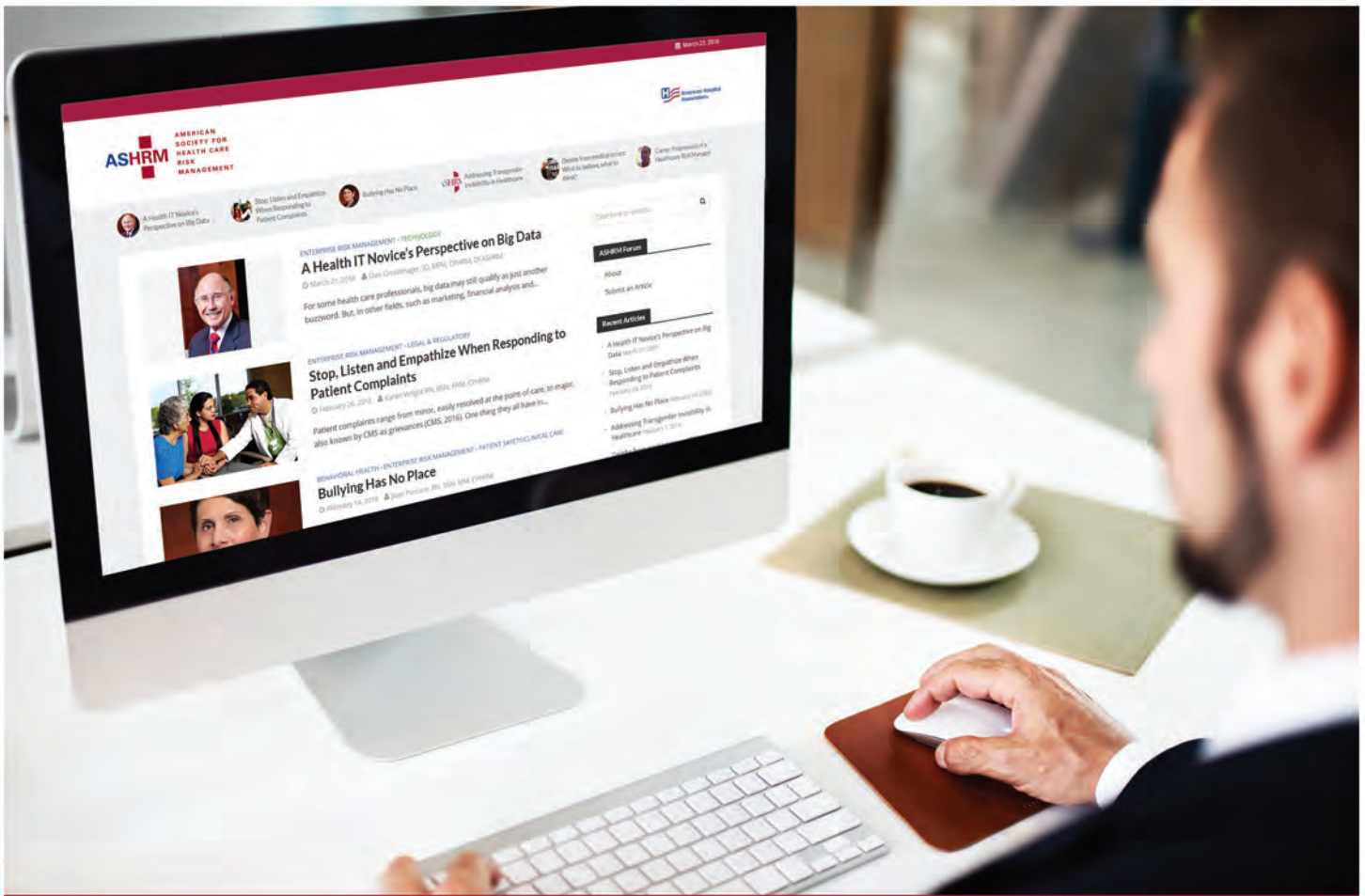


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How case law impacts risk management

By Dan Groszkruger, JD,
MPH, CPHRM, DFASHRM

Published decisions by federal and state appellate courts impact health care risk management in a number of ways, including overruling precedents, explaining and clarifying new laws and regulations, describing new and novel rules, describing new performance standards, and describing new civil rights.

INTRODUCTION

Most health care risk managers are clinically trained and experienced in various aspects of health care delivery. And it is true that the relative percentage of risk managers who are also attorneys, or who attended law school, is growing. Nevertheless, the vast majority of health care risk managers at present are not attorneys.

But health care risk managers are required to understand how new rules and changes in laws and regulations impact health care delivery, in particular for professional licensure, regulatory compliance, and liability. Often, the facility risk manager is the individual assigned primary responsibility to monitor new or changed laws and regulations, and to communicate changes to governance, facility leadership, and clinical professionals.

How do nonattorney health care risk managers monitor all the changes in laws and regulations, and effectively identify those important for their activities? One answer is by regularly reading the *Case Law Update*, published as a regular feature of the *Journal of Healthcare Risk Management*. This article explains the major ways that published cases impact licensure, compliance, liability, and health care risk management.

HOW IS CASE LAW DIFFERENT FROM STATUTES OR REGULATIONS?

Nonattorney health care risk managers tend to know that most new and changed rules impacting health care delivery arise from two major sources: (1) statutes and regulations adopted by the Congress or by state legislatures, and (2) published appellate court cases (ie, case law). Most federal laws (eg, The Patient

Protection and Affordable Care Act¹) passed in the Congress are followed by implementing regulations published by federal agencies, such as the Department of Health and Human Services (DHHS). Similarly, state legislatures adopt state-specific laws, such as professional licensing laws, and state agencies publish implementing regulations containing detailed rules.

If a new or revised statute is clear and unambiguous, adoption and enforcement tend to be straightforward. But health care laws are notorious for their complexity and ambiguity. Such rules may be challenged in court, eventually resulting in published decisions that are intended to explain, to clarify, or even to invalidate some or all parts of the new rule.

Published appellate court decisions from federal and state courts continually impact the practice of health care risk management in a variety of ways. The following sections will identify, explain, and illustrate the major ways that case law impacts risk management.

CASE LAW MAY OVERRULE PRECEDENTS

Elsewhere in this edition of the journal, the legal mechanism called *stare decisis* is more thoroughly explained and illustrated. But simply stated, the rule of *stare decisis* requires judges to give weight and deference to the prior decisions of appellate courts in the jurisdiction that previously decided the same issue. Practically, judges tend to follow prior decisions (“precedents”), unless there is a good reason not to. If there was a prior published decision deciding the same issue, the judge must choose to do one of three alternative actions: (1) follow precedent, (2) overrule the decision of a lower court, or (3) distinguish the facts of the current dispute from precedent, explaining why the prior rule should not dictate the result in the current dispute.

How a published appellate court decision may overrule precedent is illustrated by the pending challenge to the ACA. The Supreme Court of the United States (“SCOTUS”) famously ruled that the so-called “individual mandate” of the ACA was constitutional if considered a tax, under the broad taxing authority of Congress.² But, in 2017, Congress eliminated the tax penalty assessed on individuals for failing to obtain or maintain health insurance.³ Recently, the federal Fifth Circuit ruled that the ACA is unconstitutional, since Congress eliminated the tax penalty in 2017.⁴ This case has been appealed to SCOTUS, where the constitutionality of the ACA will be decided in the future.⁵

CASE LAW INTERPRETS NEW LAWS AND REGULATIONS

New statutes, both federal and state, directly impact the delivery of health care services throughout the country. Both Congress and state legislatures attempt to draft

legislation as clearly and comprehensively as possible, to adequately give notice of new rules, and to avoid legal challenges that frequently delay implementation and enforcement. However, modern medicine is complex and continually changing, resulting in confusion or ambiguity regarding the proper scope of a new law’s application, as well as workable standards for enforcement.

When a new law is adopted, in particular new laws affecting delivery of health care services, it is quite predictable that some individual or group will be aggrieved and will challenge the new law in the courts. An example would be a law designed to expand the scope of services that may be offered by licensed professionals. Expanded scope for one set of professionals may be perceived as an improper limitation of scope of practice for another set of professionals. State laws expanding the ability of registered nurses to diagnose and treat conditions that were formerly handled solely by licensed primary care physicians is a common example.

Another subject that illustrates how case law interprets new laws and regulations is discrimination against the disabled, arguably in violation of federal laws prohibiting such discrimination (eg, the Americans with Disabilities Act [ADA]⁶). Risk managers learn about how the courts enforce the ADA in the hospital environment by reviewing case law addressing specific factual settings. A recent illustration is alleged discrimination against hearing-impaired patients by failing to provide and pay for sign language interpreters. Two cases in 2018 serve to illustrate the dilemma. In one, a profoundly deaf patient asked for a sign language interpreter, but the facility refused to pay for an interpreter. A federal district court held that both state and federal civil rights laws protect hearing-impaired patients from discrimination, so the facility could not refuse.⁷ In another, the Eleventh Circuit held that a delay in providing a sign language interpreter in a hospital ED violated a patient’s rights, denying “effective communication” to resist an involuntary psychiatric hold.⁸

CASE LAW MAY CREATE NEW OR NOVEL RULES

Modern medicine and health care delivery seem to offer a virtually endless supply of new and novel circumstances where appellate courts are called upon to create rules that formerly did not exist. Technology advances often at a pace defying attempts to identify issues or problems for which new rules are required. For example, adoption of electronic storage and transmission of data (eg, electronic medical records, social media, and cell phones) has generally out-paced our industry’s ability to develop and implement new rules protecting the privacy of confidential information, or ensuring the security of private information.

The Health Insurance Portability and Accountability Act (“HIPAA”) was adopted in 1996, followed by regulations

effective in 2003.⁹ Anticipating future challenges associated with electronic storage and transmission of data, DHHS staff that authored the regulations developed new and novel language and descriptive terms to describe “protected health information” (PHI), providers (eg covered entities and business associates), and many new rules (eg, minimum necessary; more stringent state laws). Since 2003, there have been a constant stream of case law decisions, designed to assist implementation of HIPAA laws and regulations and enforcement of the Privacy and Security rules.

An interesting case from Vermont provides an illustration of the courts creating new and novel rules.¹⁰ The plaintiff, who was inebriated, lacerated her arm and drove herself to the hospital ED for stitches. The nurse who assessed the wound detected a strong odor of alcohol and administered a blood-alcohol test with a result of 0.215%. After treating the wound, the nurse took it upon herself to inform a police officer on duty in the ED that the patient was intoxicated and had driven herself to the hospital, lacking a ride home. The police officer investigated and arrested her for suspicion of driving under the influence. The patient sued the nurse for violating the confidentiality of her medical information.

The Supreme Court of Vermont recognized that the federal HIPAA law provides no private cause-of-action for breach of privacy. But the court determined that HIPAA does allow disclosure of PHI to law enforcement under certain circumstances. The Supreme Court held that Vermont will recognize a private right of action for breach of privacy, but that the patient failed to produce evidence to overcome a presumption of “good faith” (not mentioned in HIPAA) on the part of the nurse by disclosing PHI to law enforcement.

The Vermont case illustrates how new and novel problems and circumstances arise in a variety of situations, challenging the appellate courts to devise new rules to deal with each new problem or circumstance.

CASE LAW MAY CREATE NEW PERFORMANCE STANDARDS

Risk managers who handle medical malpractice claims tend to be familiar with the typical “battle of experts” when it comes to defining the professional standard of care. Describing what level of performance was expected of a competent professional “in the same or similar circumstances” is often the subject of contradictory expert opinions in court. But occasionally appellate courts announce new performance standards because a new case raises new or different factual circumstances.

One recent illustrative case from California involved a registered nurse who faced discipline before the state Board of Registered Nursing (BRN). The nurse had been arrested and convicted of shoplifting on four separate occasions. The CA BRN filed charges to restrict her nursing license,

allowing practice as a “probationary” RN, only. The appellate court held that, while misdemeanor convictions (dismissed following her completion of probation) were not admissible, the BRN properly restricted her license based on her admissions of misconduct that was inconsistent with “the trust that patients invest in professionals who have access to their personal property.”¹¹

Another example of appellate courts creating new performance standards was a case decided in 2017 by the Supreme Court of Pennsylvania. A surgeon met with a patient, explaining risks and benefits of surgery and obtained his informed consent. Later, a physician’s assistant shared additional information with the patient about inherent risks associated with the surgical removal of a nonmalignant pituitary tumor. Misadventures during surgery left the patient with residual numbness and partial blindness. The Pennsylvania Supreme Court established a new rule for surgical consents, holding that a surgeon may not delegate to a subordinate the duty to disclose sufficient information required to obtain informed consent.¹²

CASE LAW MAY DEFINE NEW CIVIL RIGHTS

In health care, providers frequently find themselves “in the middle” of disputes between parties with inconsistent, mutually exclusive civil rights. Abortion rights are perhaps the most obvious example, where individuals file lawsuits to vindicate rights of access to abortion, or to abortion-related services, allegedly obstructed or denied by individuals based on religious or moral grounds. The majority of acute care hospital beds in the United States are operated by faith-based providers, but abortion-rights organizations such as Planned Parenthood continually file lawsuits to remedy perceived discrimination that has the effect of limiting access to abortion services.¹³

Recently, a relatively new “battle of rights” has emerged over transgender patients. Individuals suffering from “gender dysphoria,” or others who genuinely believe that sex organs evident at birth conflict with “gender orientation,” have filed lawsuits seeking to compel facilities and health plans to provide and to pay for hormone therapy and gender reassignment surgery. Anti-discrimination provisions contained in the ACA have been interpreted to extend to “gender identity” (and to abortion access), but after a federal District Court’s decision in Texas granting a nationwide injunction, DHHS now declines to utilize §1557 to prosecute alleged discrimination against transgenders.¹⁴

Two recent cases illustrate how appellate courts define new civil rights. In Wisconsin, a Medicaid patient sought coverage for gender reassignment surgery, despite the fact that Wisconsin excluded coverage for “transsexual surgery.” The federal district court held that the recommended surgery was “medically necessary” and therefore entitled to Medicaid coverage. Also, the court held that the state’s exclusion violated ACA §1557, prohibiting sex

discrimination.¹⁵ In another case, the Iowa Supreme Court held that gender identity was a protected class under the state Civil Rights Act, and therefore the state Medicaid agency could not exclude coverage for “gender affirming” procedures, or refuse to pay for medically necessary gender reassignment surgery. The Iowa Supreme Court held that medically necessary procedures may not be categorized as “elective” or “cosmetic” and thereby excluded as not really necessary.¹⁶

CASE LAW MAY DICTATE CALCULATION OF FUTURE DAMAGES

Medical malpractice litigation involving alleged birth injuries suffered by newborns have produced multimillion-dollar judgments and settlements. Life care planners have emerged as pivotal expert witnesses in brain injury cases, detailing future damages (ie, medical care and related services necessary over a lifetime for impaired children). But disputes have arisen over permissible assumptions upon which life care planners based their calculations of future damages.

In California, the state Supreme Court handed down a rule that future damages must be calculated based on “fair market value” or the “reasonable value” of future life care and services.¹⁷ Life care planners hired by plaintiffs had adopted a practice of using “billed charges” as their basis for computation of future damages, even though most insurance companies and health plans were able to negotiate and pay significantly lower rates. In 2017, a state appellate court considered the issue in a medical malpractice case. The court held that an exception to the state “collateral source” rule (prohibiting admission of evidence of third-party sources of payment to reduce plaintiff’s damages proximately caused by a defendant’s negligence) applied to future damages in medical malpractice cases. The court ruled that future damages must be measured by fair market value, that is, amounts that are actually likely to be paid for future care and services.¹⁸ The new rule has resulted in much smaller judgments and settlements based on future damages.

CONCLUSION

Risk managers may stay abreast of new and changed laws and regulations by reading the *Case Law Update* published as a regular feature of the *Journal of Healthcare Risk Management*. Published decisions from federal and state appellate courts continually change and add to the rules affecting health care delivery and the practice of health care risk management. The quarterly journal provides a summary of pertinent appellate court rulings, published in a convenient and informative format, for the convenience of busy health care risk managers.

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What is case law? Why is case law important to risk managers?

By Christopher J. Allman,
JD, CPHRM, DFASHRM

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“Our common law is the stock instance of a combination of custom and its successive adaptations.”

- Learned Hand, United States District Court for the Southern District of New York

Every year, during the ASHRM Annual Conference, many of us pack the biggest concurrent session room, or, on alternating years, the big room, to hear the latest updates in and rulings from courtrooms around the country on a variety of topics, such as professional liability, the Emergency Medical Treatment and Active Labor Act (EMTALA), informed consent, privacy, and other matters in John West’s Case Law Update. Additionally, when many of us get our quarterly copy of the *Journal of Healthcare Risk Management*, we turn right to the back to read John’s article on the latest in case law.

But why? Why, aside from John’s signature dry wit and hilarious cartoons about the legal system, do so many of us make John’s Case Law Update a must-see session at the Annual Conference annually, or why do we need to know the latest and greatest in case law first, before we read the rest of the informative articles in the *Journal of Healthcare Risk Management*? To answer these questions, we must look at the role of case law (also known as common law) in the legal system and how case law can provide valuable information to risk management professionals.

TYPES OF LAW

To guide us in the role of case law and its importance to us, we must first look at the types of legal precedence that we use to determine the law and how the law is interpreted. Generally, there are three types of laws we use to guide our civic behavior: statutory law, public or administrative law, and common law. Additionally, each type of law can be found on multiple levels of government: federal, state, and local.

Statutory laws are laws that are passed by various government agencies or legislatures of a country. Thus, there are laws passed by federal and state governments, and ordinances passed by towns and cities, all having the power of law. New laws are issued to meet the needs of the citizens, to resolve outstanding issues, and to formalize an existing law.¹ Statutory laws are usually worded very broadly, as they are meant to apply to an entire community, which may be as large as entire country (federal statutes); an entire state (state statutes); or

as small as a city, village, or township, in the case of city or town ordinances.

All of the statutory laws passed by a legislative body have to conform with any unit of government superior to it. In other words, state laws cannot be contrary to federal laws, and local ordinances cannot be contrary to either state or federal law. In addition, each statute passed must not contradict the framing document of the unit of government. Generally, each unit of government—federal, state and local—has a framing document, often called a Constitution. The Constitution is intentionally drafted very broadly, as it is the overarching document upon which all laws must conform. For instance, all laws, on any level, must conform and be supportive of the US Constitution, which is the supreme law of the land. Likewise, any state statute must conform with that state's Constitution, which, in turn, must conform with the US Constitution. City ordinances must comply with the city charter, which must not be contradictory to either the state Constitution or the US Constitution. If a statute on any level is found to be contradictory to the US Constitution, or any framing document inferior to it, it is ruled unconstitutional and is generally invalidated.

Public/Administrative laws are the regulatory laws framed by various regulatory government agencies that have the authorization to do so once statutes are created by the legislature.² This administrative law is meant to further define and guide the people to whom the laws apply on specific requirements or behaviors required under the statute. For example, patient rights in a hospital are governed by the Medicare Conditions of Participation in the Code of Federal Regulations (CFR).³ However, a review of the patient rights in the CFR does not shed much light on how a hospital must institute policies and procedures and what behaviors are required of the hospital workforce to ensure a patient's rights are not violated. In fact, the wording in the CFR of many of the patient rights set forth in the CFR is very broad.

There are, however, further publications from the US Department of Health & Human Services (HHS) that provide further rules and guidance on what specific behaviors are expected of hospitals in specific situations.⁴ The guidance published by the administrative body, HHS, is intended to shed further light on the regulations passed by Congress and signed into law by the president.

Common law is also known as case law and is of two types—one in which judgments passed become new laws where there are no statutes, and the other in which judges interpret the existing law and determine new boundaries and distinctions.⁵

WHERE DOES CASE LAW COME FROM?

John West also discusses the origins of case law in this edition. However, at the risk of being slightly repetitive, it

seems that some recitation of how case law is decided is valuable to this article.

All common law, whether federal or state, starts with a filed lawsuit. There are generally two types of cases in any court system: criminal cases and civil cases. In a criminal case, the government (state or federal) files a lawsuit or charges alleging that the defendant violated a statute or law, and requests the relief of punishment via removal of some freedoms of that defendant (eg, incarceration, fines). A civil lawsuit, brought by anyone who has standing, requests that a court of law assist the plaintiff in righting a wrong either monetarily or in equity to make the plaintiff whole. Standing is the ability of a party to bring a lawsuit in court based upon their stake in the outcome. A party seeking to demonstrate standing must be able to show the court sufficient connection to and harm from the law or action challenged.⁶

Once the lawsuit is initiated, issues of law and fact are brought before the court by the parties. Issues of fact are found to be true or false by a jury. In cases in which there is not a jury, a judge may be the arbiter of the facts.

Issues of law are ruled on by a judge, depending upon how the judge interprets the law, as applied to the facts of the particular case before it. The judge, however, cannot just apply the law in any way he or she sees fit. A judge must apply the principle of *stare decisis* in his or her decision making. *Stare decisis* is Latin for “to stand by things decided.” In short, it is the doctrine of precedent.⁷ In other words, if a higher court has ruled on a legal issue, the judge must apply that higher court legal ruling to the facts in the case before the lower court and follow the legal principles set by the higher court in the case before him or her. If any party to the lawsuit believes that the judge has applied the law to the facts incorrectly, then the party may appeal the judge's ruling to a higher court for a further ruling on the correctness of the ruling of, or the application of the law by, the judge in the lower court.

The higher court discussed above to which the party in the lower court brings their case is a court of appeals, or appellate court. Appellate courts exist on both the state and federal level. Whether the state or federal appeals court has jurisdiction over the appeal of any matter depends on whether the ruling of law being appealed is a state or federal question. For example, if the ruling of the lower court being appealed is an appeal of the application of a state law, a state court of appeals would have jurisdiction over the appeal. If the matter being appealed is a federal or constitutional question (eg, a freedom of speech issue under the First Amendment), the federal appeals court would have jurisdiction.

The appellate court is a court that is set up specifically to review the rulings and application of law to the facts found in the lower court. The appellate court is often set up using a 3- or 5-judge panel who will hear arguments made by the parties on the application of the law to the specific facts of

the instant case. The appeal panel will then issue a ruling on the lower court's application of the law to the facts. The appeals court can affirm the lower court ruling, completely reverse the lower court ruling, remand the case back to the lower court for further arguments, or any combination of the above (eg, affirm in part and reverse in part, if parts of the ruling of the lower court were correct but others were not the correct application of the law to the facts).

If either party in the case being appealed believes that the application of the law to the facts of the appeals court is incorrect, they may appeal the matter again to the state or federal supreme court. Unlike the courts on the appellate level, however, an appeal to the supreme court is not guaranteed. The appealing party in the case must complete an application, called a writ of certiorari, to appeal to the supreme court. The supreme court may decide that the matter does not pose a significant enough question to hear the matter on its merits and deny the application. If the application is denied by the supreme court, the ruling in the lower court stands as the rule of law in that jurisdiction.

The state or federal supreme court, though, may also decide to hear the matter. It may make that decision based on several factors, including, that the matter is of enough importance that a supreme court ruling is necessary. On the federal level, the supreme court may also decide to hear a matter if different judicial district and circuit courts rule differently on a substantially similar federal or constitutional question. See **Figure 1**¹ for geographic boundaries of the US courts and district courts. For instance, the US Supreme Court weighed in on the constitutionality of the Affordable Care Act (ACA) in 2012 after several federal circuit and district courts issued varying rulings in 2011 regarding the "individual mandate," interstate commerce, Medicaid expansion, and tax matters; some found the law constitutional, while others found the law unconstitutional, on a variety of grounds.⁸ Ultimately, as we know, the US Supreme Court found the ACA's "individual mandate" to be a proper use of the taxing power of the United States (although this is still a matter for debate as of the writing of this article)⁹ and allowed for limited expansion for Medicaid.¹⁰ The US Supreme Court's ruling on the ACA made the ACA "the law of the land."

WHY IS CASE LAW IMPORTANT TO RISK MANAGERS?

Most of the law that the courts are called on to apply is statutory. Yet statutory interpretation languishes as a subject of study. For the most part, law students are expected to pick it up by a sort of process of osmosis. It is more fun and engaging to study cases as vignettes of real life, so the common law and common law method win out.¹¹

However, in many ways, modern statutory interpretation has become closer to common law method. By common

law method I mean the familiar process of extrapolation of underlying principles and values from disparate sources, with a view to identifying the particular rule to apply to the case in hand.¹²

The above two paragraphs are why the Case Law Update is so important to health care risk managers. Indeed, some risk managers have law degrees, but we are certainly in the minority. Whether or not one has a law degree, we all can relate to stories about events in our profession. John, through his Case Law Update, is able to provide ASHRM members with relevant, engaging and often entertaining stories that we can use to extrapolate themes and apply those themes to our own organizations. John's carefully selected cases in his Case Law Update give risk managers insight into how statutory law should be practically applied in our organizations by providing us with scenarios that could be repeated within our facilities. More importantly, the Case Law Update gives risk managers some knowledge about how a court might look at those events that occur in our organizations and how the court might interpret the statutes that apply to our everyday events. In short, by extrapolating the themes in the Case Law Update, risk managers can obtain some certainty, at least to some extent, of how often-confusing laws might be interpreted as applied to health care and the health care organization. However, it is important to note, as John so often does, that a singular interpretation of the law is not written in stone and is always subject to further litigation and judicial interpretation.

In the most extreme cases, case law sets the standard of care in health care. For instance, everyone hates the "puff-of-air" glaucoma test, otherwise known as tonometry, performed by your local eye care professional. The reason that the test is given, unfailingly, every time you go to the eye doctor, is the *Helling v. Carey* case in 1974.¹³ In that case, the Supreme Court of Washington held that not performing tonometry for all eye patients was a breach of the standard of care for medical eye professionals. Since that time, all medical eye professionals must perform the tonometry or be in violation of the standard of care for that profession and subject to professional liability. You can thank the Supreme Court of Washington for your anxiety every time you go to the eye doctor.

Finally, case law provides risk managers with guidance for the differences in state and federal law interpretation. Each state has its own set of laws. Sometimes, a state's laws vary greatly from other states surrounding it. The federal government, too, has laws and statutes within the powers reserved to it. Very broadly, state law cannot contradict federal law. State law, however, can be more restrictive than federal law, if those restrictions are not contradictory to the federal law. Since state and federal law may be quite different, and one state's law may be greatly different than another state's law, we rely on judicial interpretation of those laws to provide guidance to us on how to apply those laws within our health care organizations.

Figure 1:
Boundaries of the Federal District Court Circuits



Source: https://www.uscourts.gov/sites/default/files/u.s._federal_courts_circuit_map_1.pdf

In his Case Law Update, John has always provided risk managers with some insight into various interpretations of both federal and state law and made it relevant to the risk management profession by not only advising us how the courts have interpreted the laws but how those interpretations are applicable to risk managers and health care professionals alike.

HOW DO YOU STAY UP TO DATE AND INFORMED ON CASE LAW IN YOUR LOCAL CHAPTER?

There are many resources for risk managers to stay up to date in case law in their local chapter. These resources are of significant relevance since they are local, as they will likely be directly applicable to your organization in your state. A full list of resources would exceed the space allowable for this article. However, I would encourage you to go to the website for the American Hospital Association, or the website for your state's hospital association, and view whatever materials are available there. Most hospital association websites have an advocacy or legal section that would provide information on the latest laws and cases in your jurisdiction. I would also encourage you to visit those websites often, as rules and the judicial interpretation of those rules may change.

Another great resource for risk managers are the case law updates in your risk management chapter publications or at your chapter meetings. Some chapters make a case law update a regular part of meetings, newsletters, journals, and other publications, similar to the way ASHRM makes the Case Law Update a regular occurrence. Attending your

chapter meetings and reading your chapter periodicals can provide a great resource for the latest developments in the law.

CONCLUSION

It is easy to see why John West's Case Law Update is a must see for so many at the ASHRM Annual Conference and mandatory reading in the *Journal of Healthcare Risk Management*. Risk managers are trained to reduce uncertainty in any way we can. John's work, and case law in general, allows us some ability to reduce uncertainty in our interpretation of the law and the way it is applied in local jurisdictions and within our facilities and gives us insight into the legal system.

(Correction added April 22, 2020, after first online publication. This article was previously published under the Research Article category. Reference layout has also been updated, though the content was not altered.)

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Interview with John West

**Sue Boisvert, BSN,
MHSA, CPPS, CPHRM,
DFASHRM**

This edition of the *Journal of Healthcare Risk Management* is celebrating case law, in particular the publishing of John West's 100th Case Law Update. John is the third and most prolific author to helm the column, which has been in publication since 1987. Linda Harpster initiated the updates in the spring edition of *Perspectives in Healthcare Risk Management*, as the *Journal* was formerly known. She wrote the column for 5 years with periodic assistance from Grey Berriman, then handed it off to Karen Swisher, who wrote the column from spring 1992 to summer 1994. John West has written every column since. His first column included 5 case summaries: the Health Care Quality Improvement Act and peer review, False Claims Act and Medicare as secondary payer, unfair claim settlement by a third-party payer, advance directive/do not resuscitate, and medical malpractice. The case summaries are probably just as pertinent now as they were 16 years ago.

For those who have not met him, John West is an ASHRM icon. He has been a member since 1987 and has served on nearly every committee, including the board. He has received both the Distinguished Service Award and the President's Citation. His Case Law Updates at the annual conference are so popular he was asked to provide two sessions, and when two sessions could not meet the demand, the program was raised to a general session.

In a poetic twist of fate, his 100th column is being published in the first issue of *Journal of Health Care Risk Management* that John is fully responsible for as editor. So that we could celebrate his notable accomplishment, John agreed to be interviewed—reluctantly.

How does it feel to be publishing your 100th edition of Case Law Update?

After 25 years, I still consider being allowed to write this column as a privilege. I do appreciate that this is something that not everybody has the opportunity to do, and it fills my compulsion to write. My favorite column is always the one I am working on. I get a great deal of pleasure out of just writing each column. I build the summaries like you would build a house. First, I think of how I am going to condense the factual situation into one or two paragraphs from what might be pages and pages in the court opinion. Then I try to analyze what the court did with a couple of paragraphs, followed by why it is of interest to risk managers.

I just reread Case Law Update number one. All of the updates are named in my computer as files 001 and so on. That is how I know this is number 100. But it didn't really feel any different than number 99.

How did you get interested in case law, and what motivated you to start writing the column?

One year in the early 1990s, I attended the annual conference and saw a presenter reviewing cases that weren't very current. I was aware of all of the

decisions, and I thought to myself, “I can do that.” I accepted a position on the Legal and Regulatory Committee (now known as the Advocacy Task Force). Shortly after I joined the committee, Karen Swisher announced her intention to step down from writing the Case Law column. When Karen asked for a volunteer; I thought, “I like to write, I like to research, and I love explaining the law to people. I can probably write that,” so I volunteered. That was how I started; it was a question of being in the right place at the right time.

Your columns are always interesting to read. How do you find and select the cases?

I am a member of the American Health Lawyers Association, and I read their journal, *Connections*. I also subscribe to law blogs and a service that archives court decisions. I also read an awful lot of cases, and sometimes I go out to media sources for background because I don't fully understand the facts based on the court findings. I usually try to find 15 to 20 cases that include something that would be of interest to a lay audience, as the majority of ASHRM members are not attorneys. Sometimes I agree with the case and sometimes I do not, but I always look for a learning lesson. I look for cases a frontline risk manager can take back and say, “Is this something that can happen in our organization and, if so, what can we do about it?”

Sometimes I come across cases where I think there is probably a learning lesson in there somewhere, but the case summary is 40 or 50 pages long, really complicated, and I don't think I can simplify the material. I usually look for decisions that are between 10 and 20 pages long that I can work with, manage the summary, and have fun with. I tend to have fun with the courts and plaintiff lawyers, but I never poke fun at defendants. I am getting a case filtered through a court. The court wasn't at the scene—the court is accepting one side's version over the other, and I don't want to disparage the care that was given.

There is a long lag between when I write the column and when it gets published and people will read it. I try to avoid cases they may feel stale. There have been times, when it comes time to write the column, that I have found other more interesting cases out there. I don't want to be summarizing a case and people will be reading it a year after it was handed down.

Do you ever get fan mail?

[Laughs] No, no fan mail. I do get stopped at the conference. People will say they love the column or it's the first thing they read when they get their copy of the *Journal*. Once, I got some angry feedback when one of my editions got loose on the Internet. I had inadvertently misnamed a child who died. I don't know how it happened—I may not have gone back and double checked my summary. The individual was very upset, and I don't blame them. I try to be much more careful now. I read a

case and put it into a “to do” or “not to do” pile. Then I go through and reread every case before I start writing, just to make sure I know what the facts are and who the parties are.

Do you have any advice for budding writers?

There's always the “write what you know” advice. I tend to avoid cases that I don't know anything about. I don't consider myself an ERISA [Employee Retirement Income Security Act] expert, and I tend to avoid ERISA cases. At one point, I was including compliance cases: fraud and abuse, Stark, ant kickback and those kinds of cases. Then the Health Care Compliance Association came into being and compliance got to be a complicated field. I couldn't really do justice to a compliance case anymore, so now I tend to avoid those and stick to medical malpractice, emergency medicine, informed consent, vicarious liability, and confidentiality. I think risk managers got out of the business of doing compliance, so trying to be mindful of my readership, I stopped doing compliance cases. They're interesting, but I don't think they have learning lessons for ASHRM members.

As editor of the *Journal*, I would always put myself out there to assist anybody who has an interest in writing something. I can help with development of the idea, the writing process, and research if they need it to more fully understand the topic. I am always willing to help someone become a writer or a better writer.

You are an experienced editor as well as a writer. How does the editor feel about being edited?

I like to edit, and I do a lot of editing. I am the editor of the *Journal of Healthcare Risk Management*, and I am editing the *Human Capital Management Playbook*. I edited the *Fundamentals of Healthcare Risk Management* book that came out a few years ago and the *Claims and Litigation Playbook*.

You know editors sometimes know exactly what they are talking about and sometimes they don't. For example, a former employer required all my columns to be run through management, legal, and marketing. I got comments back like, “Do you really think we should be naming the patients in these summaries?” The cases are all public documents. They are on the Internet—just Google them. There is no real point in saying, “Plaintiff underwent X procedure and sued the doctor for malpractice.” It makes more sense to put names in the summary so that people can follow it a little better. That raised my ire a bit; I am jealous of my writing. If an editor can make constructive comments to me, I will welcome it. I am okay with someone pointing out that I am not getting my message across. At present, I send my column to Fran Charney (ASHRM's Director of Risk Management) prior to uploading it for the *Journal*. She has a light touch, and I appreciate her comments.

Your ASHRM conference Case Law Update sessions were so popular you are now a regular general session. Have you always enjoyed speaking?

It's interesting because as a child I was pathologically shy. I remember birthday parties where I made my mother send everyone home because I didn't want to be the center of attention. Now I assume the persona of a presenter rather than thinking of John West up in front of all these people because I would probably be paralyzed with stage fright. If I consider myself to be a presenter who knows how to entertain, then I can get through the program and enjoy it. Presenting has helped me to overcome my shyness.

What is your proudest achievement?

The *Journal of Healthcare Risk Management* won an award for best trade journal, and they cited Case Law Update as one of the reasons [2014 Apex Award in the category of regular departments and columns]. I am proud of that. I have also won the Distinguished Risk Manager award and the President's Citation award.

On a nonprofessional note, I am really proudest of my three daughters and two stepchildren. I have a professor, an attorney who is a health care ethicist, a mechanical engineer, and a Navy surgeon. One of my daughters died of cancer at the age of three, which left a hole in my soul from which I may never recover. Or at least I hope I don't.

What did you want to be when you grew up?

I never had a drive to be a particular thing. My stepdaughter is a Navy surgeon, and she knew from the time she was in third grade she wanted to be a doctor. In college I signed up for an aptitude test because I had no idea what I wanted to do. I got high scores in a number of professions, but my best score was bookstore manager, and I matched strongly with college professor. At one point in the early 1970s I wanted to get a PhD in English Literature and teach. But that was at a time when you could make more money as a taxicab driver than you could as an English professor. I had a family and children and I needed a solid income. So, I like to think that I have followed what I call the pinball theory of career management, which is the ball drops until it hits a bumper and careens off into another direction. If the other direction is interesting, I continue on that course. Otherwise, I wait to hit the next bumper and see what direction my career is going to go.

I think that I settled on risk management when I took my first job in risk as a safety coordinator at a hospital in Cincinnati. I worked for the risk manager. That was in 1982, and I have been in one form of risk management or another ever since. I have worked for insurance companies, brokers, hospitals, and health care systems. Now most of what I do is writing. I am semiretired, and I have a number of clients for whom I write articles on various topics. I

really enjoy it because it lets me write and it lets me learn something.

How do you want to be remembered?

In addition to my ASHRM work, I have self-published two works of fiction. I would like to be remembered as a writer. That's why I am self-publishing. I consider myself a writer and an educator, and I want to contribute to the literature.

I am a relatively ordinary guy who has been given an extraordinary opportunity and I am just happy to do it.

John, we beg to differ ...

Chris Allman, Director of Risk Management, Compliance and Insurance at Garden City Hospital and ASHRM board member: "I came into risk management with no clinical background or in any experience in health care. Prior to becoming a risk manager, I was a litigation attorney. However, when I was a newish risk manager, I attended what I think was my first Michigan Society for Healthcare Risk Management (MSHRM) meeting. John was one of the presenters at that meeting, presenting his Case Law Update. John, with his usual exceptional and dry wit, went through the then current state and federal cases and their applicability to health care risk managers. I was hooked. It was the first time that I realized that attorneys and the study of cases and litigation had a place in health care risk management. Further, it was really the first time that I realized that what happened in litigation across the country had a direct impact on the daily happenings at a hospital or in a health care system. I approached John after his presentation and thanked him for his presentation. I'm sure John just figured I was just another meeting attendee thanking him generically. However, I was truly thanking him for helping me understand the interplay between case law and risk management. Since that time, I have seen John's Case Law Update presentation and read the quarterly *Journal* article, almost every chance I have gotten to do so."

Hala Helm, Chief Risk and Compliance Officer at Palomar Health and ASHRM's 2020 President: "John's Case Law Update is always one of the most anticipated sessions at the ASHRM annual conference. His dry wit and expert storytelling make a dense subject understandable and entertaining for everyone."

Johnnye Dennis, Assistant Vice President and Claims Specialist at Lockton Companies and immediate past editor of the *Journal of Healthcare Risk Management*: "John is like 'Old Faithful' in that he always meets his commitments like clockwork and even ahead of time. He is so very dependable—a great teammate."

Matthew Hornberger, ASHRM Executive Director: "ASHRM relies on its volunteers to accomplish nearly all of its work. There are few volunteers as impactful as John West. In this issue of the *Journal*, we celebrate 100 editions

of John's contributions. I think most would agree that John's very unique and memorable discussions of health care case law are the highlight of those 100 editions.

Writing is not the only way that John has supported ASHRM. John's annual presentations on case law are so highly valued that we were forced to take the extraordinary step of making sure every conference attendee hears them. He is now a keynote presenter at every ASHRM Annual Meeting. Through his work as a volunteer, John has formed many relationships with ASHRM members. In these relationships, he has graciously taught others and had a very positive impact on the profession.

John does all of this with characteristic good nature, sense of humor, and willingness to go above and beyond for the good of ASHRM. Words are not sufficient recognition for John's contributions, but we know from his leadership and teaching that there is meaning in them. John, thank you for all you continue to do!

Endnote: Special thanks to Fran Charney and Erin Ringstrand for additional research.

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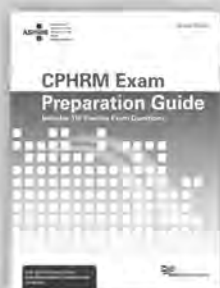
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Background of Case Law Update

By John West, JD, MHA,
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American law is a dynamic process that grows in ways that are similar to the growth of an organism. The law is something like a coral reef—it grows by accretion, while some parts die and fall off. Overall, the growth is a positive change in the nature of law, by which it is meant that the law continues to add depth and complexity. Since this edition of the *Journal of Healthcare Risk Management* is devoted to the developments in case law affecting health care providers and institutions, it may be necessary to discuss what the law is.

On a very cynical level, the law is what a judge says it is on any given day. Judges are responsible for complying with or distinguishing case law precedent, accepting new theories of a case, interpreting statutes and regulations, or determining whether a law conforms to the requirements of the US Constitution or to the constitution of the state in which the court sits. To decide a case, the court must have jurisdiction over the matter. In simple terms, *jurisdiction* is the power to “speak the law.” Readers are undoubtedly familiar with a typical courtroom scenario in which there is a judge and a jury. The jury is the fact finder in the case—the facts of the case (virtually always in dispute between the parties) are decided by the jury. The court (the judge), on the other hand, must explain the law to the jury and then allow the jury to apply the law to the facts. Judges may be wrong, and their error is corrected on appeal. But, on some level, a judge, whether trial or appellate, is always the final arbiter of the law.

There are two major legal systems (disregarding the system in Communist countries). The first is the common law tradition that the colonies adopted from England at the time that the colonies were first established. The common law tradition depends on court cases to flesh out the parameters of legal doctrines. This is different than the civil law tradition that was adopted in many countries in Western Europe, such as Germany and France, which depends on the enactment of statutes for the growth of the law. In the civil law system, the judge merely interprets the relevant statute and applies it to the current situation. Judges do not “make” law in the civil law tradition. Case law in America actually draws from both traditions.

CIVIL LAW

Common law traditions

To become the established law, the dictates of *stare decisis* are followed by the courts. In its simplest terms, *stare decisis* applies to the decisions of the highest or a higher court in the jurisdiction unless and until they are overruled by that court. This becomes precedent. Courts have three alternatives when dealing with precedent: They can follow the precedential case (it is binding precedent);

they can disagree with the precedent as applied to the present matter (which will either be affirmed or reversed on appeal); or they can distinguish the present case on its facts when compared to the facts of the precedent-setting case. It is rare, if not impossible, that two cases present with the exact same fact pattern. It is also possible for a court to adopt the decision of a court in a different jurisdiction (which has no precedential authority in this jurisdiction) because the case is persuasive, although not binding.

Because fact patterns vary widely, courts do not look to strict compliance with the facts of a precedent-setting case. Rather, they develop elements of decision to guide future cases on the same or similar issues. Ordinary negligence (which is entirely a product of common law) is a good example of the use of elements of decision. Although the elements may vary between jurisdictions, they normally include the following: The tortfeasor owed a duty to the injured party; the tortfeasor breached that duty; the victim was injured as a result of the breach of duty; and the victim suffered damages for which the law can provide compensation. Sometimes the court must find, as in the case of negligence, that all of the elements exist; in other cases, they may balance the elements that are present against the ones that are not. Negligence is a concept that has been defined, but it has virtually never been codified by statute. It is primarily a creature of case law.

There are a number of common law causes of action in American law, some of which have been codified, but most of which have not. Examples include:

- The duty of a mental health care provider to warn an identifiable third party of a credible threat of harm voiced by the provider's patient.¹
- The concept that a physician must disclose the risks and benefits of, as well as any alternatives to, the proposed invasive procedure.²
- The theory that allows a person in a "zone of danger," but who is not injured, to sue for the negligent infliction of emotional distress after seeing a close relative injured.³
- That people have a right to privacy that is constitutionally protected by federal law, although the word *privacy* does not appear in the constitution.⁴
- That people have the right to consent to medical treatment.⁵

Civil law traditions

As noted earlier, in civil law jurisdictions, the courts may only interpret (or put a "gloss" on) a statute. Courts do not make law in those jurisdictions. Although the United States is a common law jurisdiction, there are components of something akin to the civil law tradition at work, in which courts make law by interpreting a statute. A good

example is the Emergency Medical Treatment and Active Labor Act (EMTALA),⁶ which will be discussed later in this edition. The actual wording of EMTALA is intentionally broad, primarily because there are myriad fact patterns that can be alleged violations of the statute. Congress did not intend to be prescriptive in the effect of EMTALA. It allowed the courts to use the guidance of the statute to fashion remedies for alleged violations.

It is commonplace in American law for a statute to be passed that has no foundation at common law. It is rare to find a statute that is wholly self-contained, that is, one that can be applied to a fact pattern without interpretation. As a general rule, the legislature allows the courts some flexibility in interpreting a statute. In theory, this is a good thing because the legislature cannot envision and design the statute for every conceivable fact pattern. The judicial process determines how the statute operates in any given situation. However, this can also create uncertainty in this patchwork of jurisdictions called the United States. A statute can be interpreted one way in one jurisdiction and another way in a different jurisdiction, and the only final arbiter of the conflict may be the supreme court of the state or the US Supreme Court.

CRIMINAL LAW

In the distant past, there were common law crimes, such as arson (setting fire to a dwelling) or breaking and entering (damaging and entering a dwelling), that had distinct elements that had to be proven to convict the defendant or the crime. However, the law has three paramount goals: clarity, predictability, and finality. While some may take issue with the law's clarity, it is true that a codified law (which only requires that one have access to the statute book) is more easily accessible than a common law crime (which requires the ability to research case law for the law's interpretation). Thus, a codified law is more predictable and clearer than a crime that only exists in court decisions.

Another aspect of criminal law is the prohibition against *ex post facto* laws. This means that the legislature may not pass a law that criminalizes conduct after the conduct has occurred. This is different than civil law—conduct may not be considered actionable at the time it occurs but is later found to be a violation of a duty the defendant didn't know she had. There is an element of any criminal offense called *scienter*. This requires that the defendant knew, or should have known, that his conduct was illegal at the time of the act. It cannot become illegal after the fact.

This leads to another distinction between civil and criminal law: the matter of intent. In a criminal case, the defendant must, by and large, have committed the act intentionally. He or she must have intended to do the act, whether he or she actually knew that it was illegal to do so. Intent in these cases may not be terribly obvious. For example, a drunk driver did not intend to have the accident in which someone was killed, but he did intend to

drink and he did intend to drive after drinking. In a negligence case, on the other hand, the defendant may have failed to do something when he or she had a duty to do it. This can be intentional, or it can be inadvertent. In either case, the defendant may be held liable for any injury caused by the failure to perform the act. In other words, the defendant in a civil case can be held liable when he or she has not intentionally done anything.

This is not to say that courts do not interpret criminal laws in the context of the fact pattern before the court. Even criminal statutes are not self-executing. There is no such thing as automatic criminal liability. Statutes still must be interpreted by courts for a given situation. Criminal prosecutions put a gloss on the statute in much the same way that civil cases do.

ANATOMY OF A CIVIL CASE

There are thousands of cases filed every year in all of the various courts. In most cases, the matter is litigated to a conclusion (usually by settlement), and the court does not make any determinative rulings (eg, dismissing the case, granting a motion for summary judgment) available to the public. If the matter generates a determinative result that is made available to the public, it can be either a “published” decision (available in the official public records for the court) or “unpublished” (not available in the official public record for the court but may be available in the court files or loose on the Internet). Unpublished decisions normally have no precedential authority. The cases summarized in Case Law Update are normally published decisions, but an unpublished decision will occasionally be made available to the public and find its way into Case Law Update. All cases summarized in Case Law Update are publicly available court decisions and are not taken from media reports on cases.

Pleadings

Civil cases can be initiated in a variety of ways. In some states, the plaintiff must file a notice of intent to sue with the potential defendant(s). In states that have enacted tort reform measures, there is usually a specific path to follow to file a lawsuit, often involving mediation. Once the preliminary formalities have been accomplished, the plaintiff files a complaint or petition, which must contain enough detail to state a cause of action against the defendants. Once the defendant has received the complaint, there is a choice to be made: The defendant can answer the complaint, or the defendant can move to dismiss the complaint.

In moving to dismiss the complaint, there are two common mechanisms that are used in different states. In many states and the federal system, the defendant can file a motion to dismiss under either Rule 12(b)(6) of the Federal Rules of Civil Procedure or its state law equivalent. A motion to dismiss challenges the complaint by arguing that it does not state a cause of action upon which relief

can be granted. In some states, the defendant can file a demurrer, which admits the truth of the alleged facts for the purposes of the demurrer, and then claims that, even if true, the plaintiff has not stated a cause of action. In either of these situations, the court is required to assume that the plaintiff can prove her allegations to be true in order to judge the sufficiency of the complaint. If the case is dismissed, this does not prove that the event of which the plaintiff complains actually happened the way the plaintiff alleges. Many of the cases summarized in Case Law Update are ones in which a motion to dismiss or a demurrer was granted or denied.

Another popular motion is the motion for summary judgment. These motions are governed by Rule 56 of the Federal Rules of Civil Procedure in the federal system, or in states that have their own version of Rule 56. Rule 56 allows the defendant to argue that the plaintiff has not raised a genuine issue of material fact; hence, the court can rule on the matter without a trial. Plaintiffs can also file a motion for summary judgment. It is noteworthy that a motion for summary judgment only settles the question of liability; the finder of the facts (court or, in most cases, the jury) must settle the question of damages. It is normally improper to move for summary judgment before discovery has concluded and the facts are established. Many cases in Case Law Update summarize decisions to grant or deny a motion for summary judgment.

Other matters that come before the trial court normally do not result in a decision that is made publicly available, and virtually all settlement agreements are confidential. Accordingly, other types of decisions are seldom summarized in *Case Law Update*.

Appeals

There are two basic types of appellate systems: two tier and three tier. In the two-tier systems, there is no intermediate court of appeals, so trial court verdicts are appealed directly to the supreme court. A three-tier system has an intermediate court of appeals that hears cases from the trial court and then, if one party is unhappy with that ruling, it can be appealed to the supreme court. The federal system is a three-tier system.

Any appellate court can issue a determinative ruling that can be made available to the public as either a published or unpublished decision. The courts of appeals can affirm the decision of the trial court or reverse the trial court's decision and send it back for further consideration or a new trial. The decision of an intermediate court of appeals can be appealed to the supreme court of the state or to the US Supreme Court. Additionally, the decision of a state supreme court can be appealed directly to the US Supreme Court. The high court can either reverse the decision of the lower court of appeals and send it back for further deliberations or affirm the court's decision. Many cases summarized in Case Law Update are appellate court decisions.

CONCLUSION

Case Law Update provides a snapshot review of developments in the law triggered by court decisions. It is not possible to summarize all of the health care decisions that are handed down, and many would not be very interesting anyway because they concern matters of legal process or pleading that are not of interest to a general readership. Some cases turn on a point of law that is specific only to a particular jurisdiction; hence, they are not selected. Additionally, the cases that are selected are ones that are of general interest and that contain a learning lesson (“a teachable moment”) for risk managers, health care providers, and health care facilities.

(Correction added April 22, 2020, after first online publication. This article was previously published under the Research Article category. In addition, the bio previously read “Emergency Medical Treatment and Labor Act, 42 U. S. C. § 1395dd.”)

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Learning the developments in EMTALA jurisprudence through the lens of John West's "case law update"

By
Robert A. Bitterman, MD,
JD, FACEP

Abstract: This article covers three recurring issues concerning the federal law known as the Emergency Medical Treatment and Labor Act (EMTALA) that keep popping up in John West's Case Law Update case updates, and consistently bedevil hospital risk managers. First, what exactly constitutes an "appropriate" medical screening examination; second, when is a patient actually "stabilized" under EMTALA; and third, does the EMTALA obligation really "disappear" when a patient is admitted to the hospital? The editors wanted to analyze topics that challenge the courts to "get it right" on the law and that drive risk managers crazy. EMTALA is the "poster child" for such a topic.

INTRODUCTION

Like almost everyone, I am a big fan of John West's column in the ASHRM journal (*JHRM*). Each one extracts relevant, though sometimes distressing, valuable lessons from recent case law. He also provides timely, lucent, practical risk management recommendations for his readers. The emergency department (ED) features prominently in the cases discussed—it is, after all, the number one source of civil litigation against hospitals. But one befuddling issue stands out above all others—the Emergency Medical Treatment and Labor Act, the federal law known as EMTALA.

In this issue of the journal, the editors wanted to analyze topics that challenge the courts to "get it right" on the law and that drive risk managers crazy. EMTALA is the "poster child" for such a topic.

John covered many diverse EMTALA subjects over the years, but three recurring issues in particular keep popping up in the case updates and consistently bedevil hospital risk managers.

First, what exactly constitutes an "appropriate" medical screening examination; second, when is a patient actually "stabilized" under EMTALA; and third, does the EMTALA obligation really "disappear" when a patient is admitted to the hospital?

WHAT CONSTITUTES AN “APPROPRIATE” MEDICAL SCREENING EXAM UNDER EMTALA?

Neither the statute nor its implementing regulations specifically define what constitutes an “appropriate” medical screening examination; so first, it is essential to understand the purpose of EMTALA’s mandated medical screening exam (MSE). The MSE’s purpose, *and only purpose*, is to determine whether or not an “emergency medical condition” (EMC) exists, as that term is defined by EMTALA.¹ Consequently, the *only* EMTALA duty of the person performing the MSE is to determine whether the patient has an acute medical condition of sufficient severity that the absence of immediate medical attention could reasonably be expected to result in serious adverse consequences.¹

Furthermore, determining whether an EMC is present does not require a diagnosis, a differential diagnosis, or a “medical plan of care” (contrary to the claim by at least one Medicare and Medicaid Services [CMS] Regional Chief Medical Officer that this triad is required). For example, if a patient presents unconscious, cyanotic, and in respiratory arrest, the emergency physician does not need to know the specific etiology of the patient’s condition or even consider a list of possible reasons for the patient’s presentation. He or she knows instantaneously that the patient’s condition is of sufficient severity that in the absence of immediate medical attention the patient is likely to die. Thus, the MSE has been conducted and completed in that instantaneous moment.

What do the courts consider an “appropriate” MSE under EMTALA?

This vague descriptor of the screening exam, “appropriate”, was initially the most litigated word in the statute, as the courts struggled to interpret its meaning. One appellate court judge pronounced when deciding the standard to apply in judging whether a hospital’s screening process complied with EMTALA:

Appropriate is one of the most wonderful weasel words in the dictionary, and a great aide to the resolution of disputed issues in the drafting of legislation. Who, after all, can be found to stand up for “inappropriate” treatment?²

Presently, however, all of the federal appellate courts are in near universal agreement on the elements of an “appropriate” medical screening exam. The two seminal cases were *Cleland v Bronson Health Care Group* and *Gatewood v Washington Healthcare Corporation*, in which the courts held that appropriate means “care similar to care that would have been provided to any other patient, or at least not known by the providers to be in any way insufficient or below their own standards.” What is appropriate is determined “not by reference to particular outcomes, but instead by reference to a hospital’s standard screening procedures.”^{3,4}

All of the other circuits followed the analysis of *Cleland* and *Gatewood*, generally stating that “the hospital satisfies the requirements of EMTALA if its standard screening procedures apply uniformly to all patients with similar circumstances.”^{5,6}

In other words, whether a hospital’s MSE was “appropriate” is based on whether the examination was performed in a manner similar to other patients with the same or similar symptoms, not by whether the medical condition was correctly diagnosed. It is a “process” analysis, not an “accuracy” analysis. This is consistent with Congress’ stated objective of EMTALA: to prevent disparate examination and treatment among patients. Thus, if physicians and hospitals follow their own standard screening policies and procedures they do not violate EMTALA, irrespective of whether the screening examination is negligent under state malpractice laws.^{3,4}

Furthermore, the courts hold that the relevant factor is whether the hospital *perceived* the patient to have an EMC, not whether the patient actually had an EMC and not whether the examining physician or hospital *should have known* an EMC existed. The standard is a *subjective* one: the hospital’s actions are viewed in terms of its actual diagnosis, not in terms of what the diagnosis should have been. If the hospital performs an appropriate MSE and, in good faith, determines that no EMC exists, the courts will not retrospectively review that decision.

Thus, the courts hold that “appropriate” screening does not evoke questions regarding the standard of care. For example, the Fourth Circuit has repeatedly reaffirmed that “EMTALA is not a substitute for state law malpractice actions, and was not intended to guarantee proper diagnosis or to provide a federal remedy for misdiagnosis or medical negligence.”⁷

Thus was born the federal courts’ oft repeated mantra, “EMTALA is not a federal malpractice act.” However, this mantra arose before plaintiff’s attorneys learned how to frame their screening claims (and stabilization claims as discussed below). The early lawsuits for “failure to provide an appropriate screening exam” were essentially “missed diagnosis” claims: Plaintiffs claimed that the hospital emergency department failed to diagnose the patient’s emergency condition, therefore the MSE was not “appropriate,” in violation of EMTALA. This confusion in the early court cases was due to simple pleading errors by plaintiff attorneys who had not yet grasped the interpretive structure adopted by the courts. But plaintiff attorneys learn fast.

Failure to follow hospital policies and procedures

Instead of asserting “failure to diagnose claims,” plaintiff attorneys now assert that hospitals provided disparate screening, and thus violate EMTALA, whenever the hospital deviates from its own policies and procedures

when examining the patient.^{2,8} Some examples where a court held that a hospital could be found liable for failure to provide an appropriate MSE because it did not follow its own policies include (and these should disquiet ED risk managers):

- failure to follow an ED policy requiring the triage nurse to reassess all triaged ED patients in the waiting room every 2 hours, when the patient languished unexamined for 11 hours⁹;
- failure to take a 6-year-old child's blood pressure at triage or repeat his vital signs before discharge, both of which were required under the hospital's written ED medical screening policy¹⁰;
- the hospital's policy required all nurses conducting ED triage to have worked at least 6 months in an ED and completed qualifying triage training. The nurse who triaged the patient had neither the requisite experience nor the required formal training, and the court determined the nurse's grossly negligent care led to the patient's death¹¹;
- another hospital's policy stated that "Any patient arriving at the ED will be triaged by an ED nurse and assessed by an emergency physician." The patient was triaged by a paramedic, not a nurse, and the MSE was done by a nurse practitioner (NP), not an emergency physician—both in violation of the hospital's medical screening exam process.¹²

Note that this policy required all patients to be seen by an *emergency* physician. This policy not only meant the NP could not see a patient on her own, it also meant that no other credentialed member of the medical staff could examine and treat one of his or her patients in the ED, without the *emergency* physician also examining the patient.

Which providers are "appropriate" and allowed to medically screen patients in the hospital's emergency department (or labor and delivery department) is governed by federal regulations (and is a complex EMTALA topic worthy of its own full length article).¹³

Once a hospital sets its own medical screening standards, it will be held to those standards under EMTALA, even if they are higher or different than the prevailing standards in the community. Moreover, any *material* departure from that standard screening process constitutes inappropriate screening in violation of EMTALA. Fortunately, *de minimis* deviations from policies typically do not lead to liability under EMTALA, for example, a 12-minute delay in assessment by a triage nurse, or taking only some relevant history instead of a "complete" medical history, or a clerical deficiency in record keeping.¹⁴ As the Tenth Circuit noted in *Repp v Anadarko Municipal Hospital*, "to hold otherwise would impose liabilities on hospitals for

purely formalistic deviations when the policy had been effectively followed."¹⁴

Must a hospital act with an improper motive to be held in violation of the medical screening requirement?

The federal courts disagree over only one aspect of the screening exam: whether an improper motive is necessary for a hospital to be liable under EMTALA. In the Sixth Circuit, which governs the states of Michigan, Ohio, Kentucky, and Tennessee, a plaintiff must prove not only that the hospital failed to follow standard screening procedures but also that the hospital had an illicit motive for failing to follow its standard procedures.^{3,15}

The Sixth Circuit defines improper motives to include insurance status or other financial reasons, as expected by the legislative purpose of EMTALA, but adds to the definition nonmedical prejudicial reasons such as race, sex, politics, occupation, education, personal prejudice, drunkenness, HIV status, and spite. EMTALA, at its core, is a nondiscrimination statute; any disparate treatment of a patient in an emergency department for nonmedically indicated reasons is generally considered against the law.³

Every other circuit holds hospitals liable for disparate screening regardless of the hospital's motivation, because the plain language in the statute does not include motive as a necessary element for EMTALA liability.¹⁶ The other circuits believe that the Sixth Circuit's conclusion—that "appropriate" incorporates a hospital's motivation—"strains any common sense meaning of appropriate."³

The U.S. Supreme Court in *Roberts v Galen of Virginia, Inc.*, the only EMTALA case to reach the Supreme Court, expressly declined to rule on whether the improper motive test was applicable to allegations of an inappropriate screening examination.¹⁷ In *Roberts*, the Supreme Court ruled that the motive element did not apply to claims under EMTALA's *stabilization* requirements, but it declined to decide whether motive applied to the *screening* requirement. In a footnote, the court may have hinted at the direction it was leaning by noting that all the circuits except the sixth used the disparate treatment test alone and did not require a motive element to prove a violation of the law.¹⁷

What do the government enforcement agencies consider an "appropriate" MSE?

The CMS and the Office of the Inspector General (OIG) take the incredible (and legally indefensible) position that the interpretation of federal law by the federal judiciary, which is the branch of our government constitutionally appointed to interpret the law, does not apply to them. So unlike the courts, CMS and the OIG routinely retrospectively second-guess physicians' judgment. If their Quality Improvement Organization (QIO) reviewing

physician opines that the hospital or examining physician *should have* determined that an EMC was present (ordinary negligence standard—an objective standard rather than a subjective one), they will cite the hospital for failure to provide an “appropriate” MSE, and for failure to stabilize that EMC even though the physician did not know or determine the EMC existed.

The government agencies simply ignore the interpretation by the federal appellate courts, but it gets even worse. CMS’s own EMTALA guidelines state that a patient’s clinical outcome is not a proper basis for determining whether an appropriate screening was provided, and that the peer review physicians are to use the information available to the hospital *at the time* the alleged violation took place in their determination.¹⁸

Nonetheless, CMS consistently provides the QIO reviewing physicians all additional clinical data known from events that occurred *after* the incident in question. For example, if EMTALA compliance is at issue from one hospital ED visit, the CMS regional office will provide the reviewing physician all the diagnostic lab results, imaging studies, consultations, and the ultimate diagnosis and clinical outcome learned from later ED visits, hospitalizations, or even at autopsy.¹⁹

Providing data from later medical interventions or subsequent events to the reviewing physician are wholly unnecessary for, and is prejudicial to, the physician’s medical decision-making. CMS is knowingly introducing improper potential hindsight bias in the reviewing physician’s opinions.

This dichotomy between how the federal courts interpret EMTALA’s “appropriate” medical screening requirement and how the agencies enforce their view of what’s an “appropriate” MSE is what drives risk managers crazy. Unfortunately, it is just something that must be dealt with, at least until a hospital takes CMS or the OIG to court to establish additional legal precedent.

Risk management considerations

- The persons conducting the MSE should always document whether they determined an EMC existed. The ED chart should include check boxes (☐) to indicate “No EMC present” or “EMC present” and include a line _____ to name the EMC identified. This will at least eliminate some potential litigation against the hospital under EMTALA (see the “stabilized” section below), even if it does not dissuade CMS or the OIG.
- Hospitals should undertake proactive reviews of their ED policies and procedures, especially those centered on the EMTALA-mandated MSE requirement. The objective is to avoid liability for “failure to follow your own rules.” No hospital needs to invite additional civil liability and government scrutiny through feeble

drafting and wanting implementation of its own policies.

- If healthcare providers deem it prudent to deviate from the hospital’s screenings policies and procedures they should be mindful to document their rationale in the medical record.
- The hospital’s governing body must formally designate, in writing, which healthcare professionals are designated qualified to perform MSE in the emergency department (and L&D) on behalf of the hospital, carefully following the CMS regulations and interpretive guidelines on point.²⁰

WHEN IS A PATIENT ACTUALLY “STABILIZED” UNDER EMTALA?

Before deciding if a patient is “stabilized” under the law, it must first be established that the hospital actually has a legal duty “to stabilize” the patient. Two conditions precedent must be satisfied before the hospital has an obligation to stabilize a patient under EMTALA.

First, the hospital must *determine* that the patient has an EMC, as that term is defined in the statute.²¹ If the MSE fails to detect an emergency condition, EMTALA ends, and the hospital incurs no stabilization duty.

This first requirement has been encapsulated by the federal courts to mean that the hospital must have *actual knowledge* that the emergency condition exists before the duty to stabilize that emergency condition is triggered. As stated by the Fourth Circuit, “the plain language of the statute dictates a standard requiring actual knowledge of the emergency medical condition by the hospital staff.”²² The Ninth Circuit holds that “a hospital has a duty to stabilize only those [emergency] medical conditions that its staff detects.”²³ Every federal appellate court requires the plaintiff to prove the hospital or physician had actual knowledge of the EMC before a “failure to stabilize claim” can proceed.²⁴

Furthermore, considering or including a particular emergency condition in a differential diagnosis, or “ruling out” that emergency condition does not constitute actual knowledge of that emergency condition, even if the hospital *should have* recognized the existence of that emergency condition and was negligent in failing to recognize it. Hospitals are only obligated to stabilize emergency medical conditions they actually diagnose, not what a plaintiff alleges they *should have* identified. For example, in *Moses v Providence Hospital and Medical Centers, Inc.*, the court held “to the extent Plaintiff argues that the hospital’s physicians were negligent in failing to recognize that plaintiff had an emergency medical condition, such an allegation is reserved for state malpractice law.”²⁵ Likewise, in *Vickers v Nash General Hospital* the court stated “EMTALA does not hold hospitals accountable for failing to stabilize conditions of

which they are not aware, or even conditions of which they should have been aware.”²⁶

This first legal condition precedent to the duty to stabilize emphasizes how important it is for the examining emergency physician to document the presence or absence of an EMC after completing the medical screening exam. As noted earlier, this is a *subjective* determination, not an *objective* standard. Contemporaneous documentation in a patient’s medical record using legal terminology such as “no EMC identified” is clear evidence that the hospital did not have actual knowledge that an EMC existed, and hence no stabilization duty under EMTALA. Without such documentation, later testimony by the treating physician concerning lack of actual knowledge may not be determinative, leaving whether the hospital actually knew of the patient’s EMC as a question of fact for the jury.

If the screening physician determines that an emergency condition(s) exist, he or she should specifically delineate that emergency condition(s) in the medical record. That way the hospital’s duty to stabilize will be limited to the identified emergency conditions, and not any other existing emergency condition that may have been missed.

The second condition necessary before the hospital has an obligation to stabilize a patient under EMTALA is that the patient must be *transferred* away from the hospital. “By its own terms, the statute does not set forth guidelines for the care and treatment of patients who are not transferred.”²⁷ The appellate courts have stated unequivocally, “the hospital must have ‘bade farewell’ to the patient before it can be held to have failed to stabilize the patient,”^{2,28} and “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.”²⁹

Accordingly, the defined meaning of “transfer” in the EMTALA statute is highly relevant here. It includes not just transfers to other hospitals but also all discharges from the hospital, including the emergency department, unless the person has been declared dead or leaves the hospital without the hospital’s permission.³⁰

For example, if the ED fails to search and secure an actively suicidal woman who presented with an intentional drug overdose, negligently allowing her to double overdose in the ED and kill herself, there is no EMTALA liability for failure to stabilize her. Death in the ED is an absolute defense to a “failure to stabilize claim” under EMTALA, because by definition the patient was never transferred. Hopefully, it is not a defense a hospital wants to invoke on a regular basis, but it is an affirmative defense that hospital attorneys sometimes overlook when defending a civil EMTALA claim or dealing with CMS and the OIG.³¹

Similarly, if the patient with an emergency condition leaves the ED against medical advice the hospital is relieved of its EMTALA duty to stabilize the patient, because the law

specifies that anyone who leaves the hospital without the hospital’s permission has not been legally transferred.³⁰

The key point to understand is that the duty to stabilize under EMTALA does not impose a standard of care prescribing how physicians must treat a patient’s emergency condition while in the ED, it only prescribes a *precondition* that the hospital must satisfy if it intends to transfer or discharge the patient. Therefore, a hospital cannot violate EMTALA’s duty to stabilize unless it transfers the patient.³²

So now, assume that the hospital has determined a patient has an EMC and it intends to transfer or discharge the patient, what must it do legally “to stabilize” the patient in accordance with EMTALA? When is a patient actually “stabilized” under EMTALA?

The statute specifically defines the duty “to stabilize” and when the patient is “stabilized.”

When a hospital determines that a patient has an emergency medical condition it is required:

to provide for such further medical examination and treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely *to result from or occur during the transfer* of the individual from a facility.³³

Additionally, “stabilized” is defined to mean

with respect to an emergency medical condition ... that no material deterioration of the condition is likely, within reasonable medical probability, *to result from or occur during the transfer* of the individual from a facility.³⁴

EMTALA’s stability definitions are not written in medical terms as understood by medical professionals, rather, they are written in terms of *transfer* (which includes discharges from the ED), which is entirely logical considering the historical underpinning of the statute, to prevent hospitals from transferring or discharging patients (“dumping them”) for economic reasons before their emergency conditions were sufficiently treated to ensure a safe transfer. Thus, if a patient can be sent from one hospital to another and it is reasonably foreseeable that no material deterioration of the emergency condition will result during or from the transfer, then the patient has been legally stabilized. It really is as simple as that.

Furthermore, this definition of “stabilized” is a legal definition, not a medical definition. When the ED determines a patient has an emergency condition, treats that emergency condition, and then transfers or discharges the patient, the hospital’s compliance with its duty to stabilize will be judged by whether the condition of the patient at transfer met this legal definition.

For example, if a patient presents to the ED with anaphylaxis and is treated with medications and IV fluids, then discharged a few hours later and dies shortly after, the litigated issue will be whether it was likely, within reasonable medical probability, that the patient would materially deteriorate upon discharge. This is a national standard under federal law, not a local standard under state malpractice law. However, it is also an “objective” standard, based on the facts and circumstances at the time of discharge, subject to retrospective analysis just like ordinary negligence standards. Was it reasonable to send the patient home then, or were more medicine, more IV fluids, and more time medically indicated before discharge?

In essence, the decision on whether an individual’s emergency condition had been stabilized becomes an ordinary malpractice standard, subject to the usual “battle of the experts.” Thus, the federal courts’ mantra—“EMTALA is not a federal malpractice act”—becomes empty banter once a hospital determines that an individual has an EMC. A physician’s diagnosis of an EMC, as defined by EMTALA, turns every civil malpractice case of inadequate treatment into a federal claim for failure to stabilize whenever the patient is transferred or discharged.

When do the federal courts consider a patient “stabilized”?

The federal courts have always uniformly followed the plain language of the statute to hold that “if no material deterioration of the patient’s emergency medical condition is likely to result within reasonable medical probability as a result of the transfer, then the patient has been stabilized” (see, for example, *Gatewood v Washington Healthcare Corp.*, or *Thornton v Southwest Detroit Hospital*).^{4,35}

They also uniformly do not require resolution of the patient’s emergency condition. Illustrative cases include *Green v Touro Infirmary* in which the Fifth Circuit held that “EMTALA does not impose a duty to fully cure an EMC before transferring or discharging a patient,”³⁶ and the court in *Nieves v Hospital Metropolitan* which pointedly stated that “EMTALA requires only that a hospital stabilize an individual’s EMC; it does not require a hospital to cure the condition.”³⁷ Thus, for example, a suicidal patient’s suicidality does not need to be resolved in order to transfer the patient in a “stabilized” condition to a psychiatric hospital for further care.

The courts also hold that a hospital’s duty to stabilize only arises *at the time of transfer or discharge*.²⁸ The court in *Nieves* stated “To determine whether a patient was stabilized, a court examines the patient’s condition at the time of the transfer or discharge.”³⁷ A decade later the Sixth Circuit confirmed that the only time a hospital has a duty to stabilize a patient with an EMC is *at the time of transfer or discharge*. In the case of *Moses v Providence Hospital*, the court held that “EMTALA requires a hospital

to treat a patient with an emergency condition in such a way that, upon the patient’s release, no further deterioration of the condition is likely.”³⁸

Revisit our suicidal woman who presented with an intentional drug overdose and was negligently allowed to double overdose in the ED. This time, instead of causing death, the second overdose puts her in a coma for which 12 hours later the ED transfers her to a hospital with neurological expertise. The EMTALA issue will be whether or not she was stable *at the time of the transfer*, not whether the hospital negligently failed to adequately search and secure her 12 hours earlier. If she was safely transferred to the neurological hospital with no deterioration of her coma state, then she had been stabilized at the time of transfer and there is no EMTALA liability for failure to stabilize her during her stay in the ED. The hospital’s alleged negligence of failing to medically stabilize her by preventing her second overdose is a question of ordinary malpractice under state tort law, not an EMTALA issue.

Therefore, for purposes of EMTALA, it does not matter what happened in the hours, days, or even weeks (as for some boarded psychiatric patients) that the patient was in the ED or in the hospital; what matters is the patient’s condition at the time of transfer or discharge.

When do CMS and the OIG consider a patient “stabilized”?

The government enforcement agencies’ view of stabilization diverges widely from the requirements of the statute and the interpretations of the federal appellate courts and is best exemplified with respect to the care of psychiatric patients in the ED.

The definitions of stability in CMS’s EMTALA regulations are exactly the same as the definitions in the federal statute.³⁹ In addition, in its EMTALA Interpretive Guidelines, CMS has specifically defined psychiatric patients to be stable “when they are protected and prevented from injuring or harming him/herself or others.”⁴⁰

In accordance with the statute, the regulations, and CMS guidelines, hospitals and emergency physicians believe that the ED can stabilize psychiatric patients in the ED and then transfer them in stable condition to a psychiatric hospital for additional psychiatric evaluation or inpatient care. Completely addressing any medical issues such as overdoses or agitation (“medical clearance”) coupled with removal of the means and opportunity to harm self or others (search to remove weapons or dangerous medications; secure with sitters or police to intervene if necessary to prevent harm or elopement; transfer securely and safely by ambulance or police) certainly “protect and prevent a psychiatric patient from self-harm or harm to others.”

Moreover, the hospital has provided sufficient “medical examination and treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual” to an accepting psychiatric facility—which is all that EMTALA requires.⁴¹

CMS and the OIG, and their QIO physician reviewers claim that these patients are not stable at the time of transfer, and the most common “rationale” provided is that “the patient still required psychiatric evaluation and treatment” or that “the patient required further evaluation and care.” They often do not evaluate or even consider the individual medical risks associated with the transfers, or attempt to address whether the patient’s suicidal ideation or psychiatric condition was likely, within reasonable probability, to materially deteriorate en route or as a result of the transfer—despite specific instructions in the CMS QIO Physicians’ EMTALA Worksheet requiring them to conduct such an analysis.⁴²

Whether the patient still needs further psychiatric evaluation and treatment is not the correct standard to apply when determining whether the patient is stabilized under EMTALA. The proper and precise question to ask under EMTALA is *whether within reasonable medical probability it was likely that the patient’s emergency condition would materially deteriorate during or as a result of the transfer*. If the answer is “yes,” then the patient was unstable at the time of transfer. If the answer is “no,” then the patient was stable at the time of transfer, and any further psychiatric evaluation and treatment can be provided at the accepting facility or on an outpatient basis and its provision is not governed by EMTALA in any way.

These patients are not being transferred for *stabilization* of their psychiatric emergency condition; they are being transferred for further *treatment* of their psychiatric condition. The distinction between providing *legally required stabilizing* care compared to providing *additional medical treatment* poststabilization is what the government (and many a health care provider) fails to understand. EMTALA only requires *stabilization* of the patient’s emergency condition; it does not require definitive *treatment* or *resolution* of that emergency condition.

Additionally, the government refuses to analyze the psychiatric patient’s condition only “at the time of transfer” to determine if the patient has been “stabilized”; instead, unlike the courts, it considers all of the care provided (or what they believe should have been provided) during a patient’s entire ED stay to be governed by EMTALA. Said another way, if a psychiatric patient is boarded in the ED for 5 days, CMS and the OIG consider all medical services during that time to be under theegis of EMTALA, rather than just assuring that on day 5 the hospital transferred or discharged the patient in stabilized condition in compliance with the law.

Lastly, CMS and the OIG assert that suicidal psychiatric patients remain unstable until they are no longer suicidal, and therefore the patients cannot be transferred in a stabilized condition.^{43,44} This interpretation proffered by CMS and the OIG is indisputably wrong. It totally ignores the expressed definition of “stabilized” in the EMTALA statute, CMS regulations, and CMS’s EMTALA Interpretive Guidelines. It is also contrary to every single federal appellate court opinion on the definition of “stabilized” under the law. (For a more detailed legal analysis of when psychiatric patients are stabilized under EMTALA, see Ref. 44.)

The American Hospital Association and Federation of American Hospitals believe the government has overstepped its authority and is misinterpreting EMTALA with respect to the screening and stabilization of psychiatric patients. They recently sent an extensive white paper to the Chief Medical Officer of CMS expressing their concerns and requesting CMS rein in the enforcement of EMTALA by its regional offices.⁴⁵

The American College of Emergency Physicians (ACEP) shared the concerns of the hospital associations regarding psychiatric patients, and invited CMS and the OIG to one of its recent national meetings to discuss the relevant EMTALA issues. It also issued an official policy statement regarding the interpretation of EMTALA, stating that “EMTALA investigators, as well as trial courts dealing with medical malpractice litigation, have broadened the interpretation of these terms far beyond the legislative intent and legal definitions cited in the statute. It is the policy of the American College of Emergency Physicians that EMTALA should not be interpreted to extend beyond the actual statutory language with respect to an EMTALA investigation or when considered in conjunction with medical malpractice litigation.”⁴⁶

Last year, subsequent to the concerns presented by the professional associations, CMS issued a “Q&A” memo on “EMTALA and Psychiatric Hospitals,” which in this writer’s opinion did not materially address those concerns. The CMS memo can be reviewed at <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/Survey-Certification/GenInfo/Downloads/QSO-19-15-EMTALA.pdf>

Risk management considerations

- It bears repeating: the person conducting the MSE should document the presence or absence of an EMC. “No EMC Identified” is clear evidence that the hospital did not have actual knowledge that an EMC existed, and hence no stabilization duty under EMTALA.
- In a similar vein, the screening physician should specifically identify any emergency conditions diagnosed, so that the hospital’s duty to stabilize is limited to the identified emergency conditions, and not any other existing, but unapparent emergency conditions.

- Any patient diagnosed with an emergency condition, who is treated and ultimately transferred or discharged from the emergency department, should be reexamined at or near the time of transfer or discharge. This is especially true for patients experiencing prolonged stays or boarding in the ED, such as psychiatric patients. It is the patient's condition at the time of transfer or discharge that determines if the patient was stabilized in compliance with EMTALA.
- EMTALA is indeed a federal malpractice law for those patients diagnosed with an emergency condition that are ultimately transferred or discharged from the emergency department. Document the patient's stability at the time of disposition using the language of the definition of "stabilized" in the EMTALA statute.

DOES THE EMTALA OBLIGATION REALLY "DISAPPEAR" WHEN A PATIENT IS ADMITTED TO THE HOSPITAL (AKA. THE "ADMISSION DEFENSE")?

For many years, the courts, government agencies, and EMTALA pundits debated whether EMTALA ends upon admission or extends indefinitely until the patient admitted via the ED is eventually transferred or discharged.

Early court opinions, particularly in the Sixth Circuit, held that EMTALA's duty to stabilize continued to apply throughout the patient's entire stay in the hospital, no matter how long.^{35,47} Later court opinions took the opposite position.⁴⁸

CMS did not address the issue until 2002, when it first proposed regulations expressing its intent to apply EMTALA to inpatients admitted through the ED.⁴⁹ The medical community, particularly hospitals, vehemently objected and shortly thereafter CMS reversed itself, publishing in late 2003 "final" regulations holding that EMTALA ended when the ED patient was formally admitted to the hospital.⁵⁰ In 2008, it reexamined the issue and maintained its position.⁵¹ In 2010, it once again solicited comments on whether EMTALA should apply to inpatients, and in response issued additional regulations in 2012 finally confirming that EMTALA ended upon admission to the hospital.⁵²

There were basically three reasons behind CMS's decision. First, since admission established a doctor-patient relationship and a hospital-patient relationship subject to ordinary state malpractice law, EMTALA was no longer necessary. Second, other Medicare conditions of participation protect hospital inpatients, even if they are not covered by Medicare. And third, determining that EMTALA ended upon admission had the advantage of setting an unambiguous "bright line" for compliance, enforcement, and liability.⁵⁰

CMS also considered the court decisions on the issue, and ultimately endorsed the logic in the opinions of the federal appellate courts, particularly the Ninth Circuit case of *Bryant v Adventist Health System*.^{23,27}

In the years that followed, CMS's proclamation, or "admission defense" for hospitals as it became known in the malpractice arena, withstood the inevitable assault from the plaintiffs' bar. Virtually all federal district and appellate case laws upheld CMS's interpretation and regulation as legitimate and legally binding.⁵³

Then in 2009 came the Sixth Circuit case of *Moses v Providence Hospital* that muddied the waters once again.³⁸ Twice before, in 1990 and 1997, the Sixth Circuit Court of Appeals had held that admission did not end EMTALA.^{35,47} But both cases occurred before CMS published its rule in 2003, stating that EMTALA did indeed end when the hospital admitted the patient in good faith.

In *Moses*, the Sixth Circuit stuck to its own interpretation of EMTALA. It determined that the CMS regulation was contrary to EMTALA's plain language, which requires a hospital to "provide ... for such further medical examination *and such treatment* as may be required to stabilize the medical condition."³⁸ Therefore, the court held that the hospital was required under EMTALA not just to admit patients with emergency conditions to the inpatient setting, but to actually treat them in order to stabilize them, so that at the time of discharge no further deterioration of the emergency condition was likely.³⁸

Since the Sixth Circuit was the only outlier on the EMTALA admission issue, Providence Hospital petitioned the U.S. Supreme Court in late 2009 to accept the case and finally, once and for all, settle the issue of whether EMTALA applied after admission. The Supreme Court declined to accept the petition.⁵⁴

So at present, in the states of Michigan, Ohio, Tennessee, and Kentucky if a patient with an emergency condition is admitted through the ED, EMTALA's duty to stabilize for purposes of civil liability continues through admission until the patient is finally transferred or discharged. (CMS, though, will not cite hospitals in this jurisdiction for failure to stabilize patients after admission.) It is important to remember, and particularly relevant for hospital defense attorneys, that EMTALA's duty to stabilize attaches *only* at the time of transfer (or discharge). Consequently, the care of the patient during the hospitalization, no matter how long or even if negligent is not subject to EMTALA liability; it is only the patient's condition at the time of discharge that will be judged under EMTALA.

However, CMS's "admission defense" is not absolute; it comes with two caveats. First, the admission must be in "good" faith, with the intent to stabilize the ED patient's emergency condition. Second, the patient must be

formally admitted to the hospital, in accordance with CMS's definition of "admitted."

Admission must be in "good faith"

CMS's initial reticence to adopt admission as ending EMTALA was over a concern that hospitals would attempt to circumvent EMTALA by admitting patients and then rapidly transfer the uninsured to reduce the cost of providing stabilizing care. Consequently, CMS imposed a qualifying factor in its regulation—the admission had to be made in "good faith" and not as a subterfuge to avoid the law.⁵⁰ Thus, each case will be examined objectively under a facts-and-circumstances analysis to determine whether the hospital's actions were in good faith. If CMS or a plaintiff can demonstrate that the person was admitted but later discharged or transferred for financial reasons (before stabilization), or as a ruse to avoid EMTALA's duty to stabilize, then the hospital could still be held liable under the law. To gain a perspective on this analysis read the case of *Morgan v North Mississippi Medical Center, Inc.*⁵⁵

The patient must be "formally admitted"—as defined by CMS

The definition of "admitted" for purposes of cutting off EMTALA liability is as follows:

Inpatient means an individual who is admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services as described in §409.10(a) of this chapter with the expectation that he or she will remain at least overnight and occupy a bed even though the situation later develops that the individual can be discharged or transferred to another hospital and does not actually use a hospital bed overnight.⁵⁶

The same definition is in the Medicare Hospital Manual, which is utilized by Medicare for purposes of Medicare payment, so it is well known to hospitals.

Note that under CMS's definition admitted patients who are boarded in the ED, even if eventually discharged from the ED or transferred elsewhere and never actually get to an inpatient bed or remain overnight, would be determined to be inpatients for purposes of EMTALA and the law would not that apply to their discharge or transfer from the ED.^{50,56}

Direct admits that come through the ED and are held in the ED waiting for an inpatient bed would also meet the definition of "admitted" and be exempt from EMTALA's screening and stabilizing mandates. The key here is that the patient must have *formal written admitting orders* that either come with the patient from the admitting physician's office or in transfer from another facility, or have been called into the hospital in advance of the patient's arrival. The physician cannot send the patient to the ED "intending to admit" the patient, or claim that the patient is so sick that he "obviously will be admitted";

these patients still need to be screened and stabilized according to the law because they have not yet been "formally admitted."

Admission to "observation" status does *not* meet CMS's regulatory definition of "admitted."⁵⁰ Thus, EMTALA continues to apply to observation patients until they are stabilized or formally admitted to the hospital. For example, patients held in an ED chest pain unit or observation area continue to come under the umbrage of EMTALA. Similarly, if a hospitalist, an on-call physician, or the patient's private attendant writes the order "admit to 'OBS,'" EMTALA's stabilization duty continues to apply—observation patients have not been formally or legally admitted yet in the eyes of the government for EMTALA purposes. The physical location of the patient within the hospital (ED, chest pain center, observation unit, urgent care center, inpatient unit, monitored bed, cath lab, radiology suite, ICU, etc.) is not what counts; it is the legal status of the patient that matters—formally "admitted," an "observation" patient, or still an ED patient.

Finally, there is no separate duty under EMTALA to "stabilize before admission," and the EMTALA obligation ends upon admission "whether or not the individual has been stabilized."^{50,57} The duty "to stabilize" the patient only arises as a precondition if the hospital wants to transfer or discharge the patient instead of treating and admitting the patient. Thus, if a hospital formally admits the patient, in good faith, the EMTALA obligation "to stabilize" does indeed "disappear!"

Risk management considerations

- It is absolutely critical that the medical record contain appropriate documentation that the patient was formally admitted to ensure use of the "admission defense" to end EMTALA.
- A formal written admitting order "admit to Dr Smith" should generally be sufficient, especially if hospital policies and procedures define what admission means at your facility and the expectations for the patient and the admitting physician related to that admission. In essence, the hospital's admission process and procedure will be subject to retrospective scrutiny to determine if the hospital's formal "admission" criteria were met to cut off EMTALA liability.
- Admission to "observation status" does not count as "admitted" for purposes of ending EMTALA.

CONCLUSIONS

Time and developed case law has proven that the courts generally "get it right" when it comes to interpreting EMTALA's medical screening and stabilization mandates. The regulatory enforcement of these aspects of the law by

the various government agencies is what drives hospital risk managers and healthcare attorneys crazy.

Ensuring strict compliance with EMTALA in your hospital's emergency departments can eliminate an enormous amount of grief, liability, and costs for all concerned, and here is one final risk management recommendation—*Continue reading John West's Case Law Update every quarter!*

Congratulations John on 100 issues of the "Case Law Update." Well done; and from all of us in the risk management community and EMTALA arena, a very hearty thank you!

(Corrections added April 22, 2020, after first online publication. This article was previously published under the Research Article category. An author bio has been added.)

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ASHRM Case Law Update

By John C. West, JD, MHA,
DFASHRM, CPHRM

TRANSGENDER RIGHTS

Transgender man who was discriminated against may sue

FACTS:

Evan Minton, a transgender man who had been diagnosed with gender dysphoria, was scheduled to undergo a hysterectomy at Mercy San Juan Medical Center (Mercy) on August 30, 2016. The timing of the hysterectomy was critical because it needed to be performed 90 days before his phalloplasty, which was scheduled to be performed on November 23, 2016. Mercy is a Catholic hospital that is owned and operated by Dignity Health. As a Catholic hospital, it is governed by the “Ethical and Religious Directives for Catholic Health Care Services” (the Directives) issued by the United States Conference of Catholic Bishops. Directive No. 29 states: “All persons served by Catholic health care have the right and duty to protect and preserve their bodily and functional integrity. The functional integrity of the person may be sacrificed to maintain the health or life of the person when no other morally permissible means is available.” Directive No. 53 states: “Direct sterilization of either men or women, whether permanent or temporary, is not permitted in a Catholic health care institution. Procedures that induce sterility are permitted when their direct effect is the cure or alleviation of a present and serious pathology and a simpler treatment is not available.” When Mercy discovered that Mr. Minton’s hysterectomy was going to be performed on a transgender person, it canceled the procedure.

Mr. Minton and his physician, Dr. Lindsey Dawson, sought clarification for the cancellation and were told that such a procedure would never be performed at Mercy. They then went to the media and generated a fair amount of attention from the press. Mercy did not relent and allow the procedure to be performed there, but it did offer the services of Methodist Hospital, a non-Catholic hospital owned and operated by Dignity Health that was approximately 30 minutes from Mercy. Dr. Dawson was able to obtain emergency surgical privileges at Methodist. She performed the procedure there on September 2, 2016.

Mr. Minton filed suit for discrimination under California Civil Code section 51, the Unruh Civil Rights Act (Unruh Act), because of his sexual identity against Dignity Health. Dignity Health defended on the grounds that requiring it to perform the procedure would violate its right to religious liberty. The trial court granted Dignity Health’s demurrer (similar to a motion to dismiss) and dismissed the action. This appeal to the California Court of Appeals was taken.

ISSUE:

Did Dignity Health discriminate against Mr. Minton when it refused to allow the performance of a hysterectomy on him as part of his treatment for gender dysphoria?

ANALYSIS:

The Unruh Act requires, in part, that facilities provide “full and equal accommodations, advantages, facilities, privileges, or services in all business establishments of every kind whatsoever.” Dignity Health defended on the grounds that the application of the Unruh Act in this scenario violated Dignity Health’s free exercise of religion guaranteed by the First Amendment to the US Constitution, as evidenced by the Directives. Additionally, Dignity Health claimed that it complied with the Unruh Act when it made the requested service available by an entity that had no religious objection to the procedure. *North Coast Women’s Care Medical Group, Inc. v. Superior Court*, 44 Cal.4th 1145 (Cal. 2008).

The Court of Appeals claimed that it was deciding the case on narrow grounds, but its grounds may have been broader than it realized. The court held that Dignity Health discriminated against Mr. Minton under the Unruh Act when it flatly refused to allow him to have the procedure at Mercy. The allowance of the procedure at a different hospital did not cure Mr. Minton’s allegation of discrimination; rather, it merely mitigated his damages. The discrimination occurred at the moment that Mercy said “no,” so Mr. Minton began to accrue damages for emotional distress or other injuries at that point in time, which were mitigated at the time he underwent the requested procedure. Even though the period of time in which Mr. Minton could claim damages was short, he could still claim damages. The court of appeals held that the issue of damages for this period of time could not be decided by demurrer.

The court held that the grant of the demurrer was inappropriate and reversed the decision of the trial court.

RISK MANAGEMENT CONSIDERATIONS:

The outcome of this case is that refusing medical services to a transgender person for medically warranted treatment is impermissible discrimination in California. While it is well known that California takes a rather expansive view of the protections afforded by its antidiscrimination laws, there are other states with similarly expansive antidiscrimination laws. Facilities in states with broad protections would do well to heed the lessons of this case.

This decision stands for the proposition that a hospital may not blithely refuse, on religious grounds, to offer services to a transgender person. When presented with the prospect of performing a procedure that violates the facility’s religious mission, and the person seeking the provision is in a class that is protected from discrimination, it is acceptable to refuse to provide the service on religious grounds. However, the facility should seek, *at once*, to alleviate the effects of its decision by attempting to find another facility to provide the service(s) requested. To fail to do so could subject the facility to a claim of unlawful discrimination.

This writer is not condoning discrimination against members of the LGBTQ community. Bioethics is often a balancing act between two entities or individuals with divergent rights, interests, or beliefs, and neither of them is wrong. Sometimes, it is not possible to accommodate the interests of both parties, but sometimes it is.

Minton v. Dignity Health, No. A153662 (Ct. App. Cal. September 19, 2019)

MEDICAL INFORMATION

Blood alcohol results discoverable by law enforcement without warrant in Indiana

FACTS:

Unless there are two (or more) Tyquan Stewarts in Fort Wayne, Indiana, this is Mr. Stewart’s second appearance in Case Law Update. This case did not describe Mr. Stewart, but, according to the previous decision, *Stewart v. Parkview Hospital, Inc.*, No. 1:16-CV-138-TLS (N.D. Ind. October 20, 2017), Mr. Stewart was a 36-year-old man who suffers from posttraumatic stress disorder (PTSD), schizophrenia, and depression. He apparently also consumes alcohol to excess, at least on occasion.

On this occasion, Mr. Stewart was involved in a single-car motor vehicle accident and was taken to the emergency department (ED) at Parkview Hospital. According to the testimony of the ED physician, Mr. Stewart related that he had been drinking and lost control of his car. He was injured in the accident. Mr. Stewart also signed forms in which he consented to treatment in the ED. Mr. Stewart later testified that he had no recollection of having been treated in the ED and that, indeed, he was unconscious during that time. As part of the examination in the ED, blood was drawn and tested for an alcohol level, which apparently confirmed that he was intoxicated. Police officers responded to the ED to interview Mr. Stewart about the accident and asked for the results of the blood alcohol test. The nurses provided them with a copy of the results. Mr. Stewart was charged with driving under the influence, to which he pled guilty.

Mr. Stewart filed suit in which he alleged that the police had unlawfully received the results of the blood alcohol test without a warrant, in violation of the Fourth Amendment to the US Constitution. He also alleged that the hospital and its staff violated the Health Insurance Portability and Accountability Act (HIPAA), 42 U.S.C. § 1320d, *et seq.* by releasing his protected health information without his consent. In addition, he brought claims under Indiana law for negligence, infliction of emotional distress, battery, and invasion of privacy. The district court dismissed the federal claims and then dismissed the state law claims on the grounds that Mr. Stewart had not alleged sufficient evidence to support the exercise of pendent

federal jurisdiction. This appeal to the US Court of Appeals for the Seventh Circuit was taken.

ISSUES:

Did the seizure of the results of the blood alcohol test by law enforcement without a warrant violate the Fourth Amendment? Did the disclosure of the test results without Mr. Stewart's consent violate HIPAA?

ANALYSIS:

With regard to the Fourth Amendment claim, the court noted that an Indiana statute requires medical staff who test a person's blood "for diagnostic purposes" to "disclose the results of the test to a law enforcement officer who requests the ... results as a part of a criminal investigation" regardless of whether the person has "consented to or otherwise authorized their release." Ind. Code § 9-30-6-6(a). Additionally, the US Supreme Court has recognized that the exigent-circumstances exception to the Fourth Amendment permits police officers to order a warrantless blood draw from a conscious driver who had been involved in an accident. *Schmerber v. California*, 384 U.S. 757, 86 S. Ct. 1826, 16 L. Ed. 2d 908 (U.S. 1966). The circumstances are exigent because each hour that goes by reduces the person's blood alcohol level naturally, and there is no foolproof way to determine what an individual's blood alcohol level was at an earlier time. The court held that the officers were not required to obtain a search warrant to seize the results of the blood alcohol test.

The court noted that it is well-settled law that HIPAA does not provide a private cause of action for an alleged violation. The court affirmed dismissal of this claim.

The court did not reach the issue of the state law causes of action for battery, infliction of emotional distress, or invasion of privacy because Mr. Stewart pointed to no evidence in the summary judgment record that would call the trial court's decision to dismiss them into question. Accordingly, the court determined that he had waived any objection to the trial court's decision on his state law claims.

In conclusion, the court affirmed the dismissal of Mr. Stewart's claims.

RISK MANAGEMENT CONSIDERATIONS:

The general rule is that all health information is confidential and protected by HIPAA and/or state law unless there is a statutory exception that allows or requires disclosure without consent. HIPAA does allow disclosure to law enforcement personnel, but this is not a blanket provision that allows the release of any information that law enforcement may request. Typically, HIPAA allows disclosures that are *required* by state law. This includes evidence of a specific type of crime (gunshot wounds,

stabblings, etc.), child or elder abuse, or reportable diseases. Unless it is required by law, facilities should refrain from reporting evidence of a crime unless the patient is no longer able to report it. Instead, the patient should be encouraged to report it if he or she is the victim of a crime.

The disclosure of blood alcohol specimens or results is very controversial and primarily subject to state law. Indiana has taken a firm and decisive stand on this issue. Unfortunately, other state laws on this subject are highly variable. If state law requires the facility to take a particular action, it must do so. HIPAA does not stand in the facility's way. Unfortunately, this does not resolve the inherent conflict between Indiana's privacy protections and the requirements of the statute regarding blood alcohol. However, one must assume, that, when faced with a conundrum of this sort (ie, protect the patient's privacy or comply with state law), the courts will not place the facility in the position of "damned if you do and damned if you don't" and allow the release.

Stewart v. Parkview Hospital, No. 19-1747 (7th Cir. August 29, 2019)

STATUTE OF REPOSE

Seven-year statute of repose in Pennsylvania struck down

FACTS:

Susan Yanakos suffers from a genetic condition called α_1 -antitrypsin deficiency (AATD). Patients with AATD do not produce enough α_1 -antitrypsin, a protein synthesized in the liver that plays an important role in protecting the lungs from damage. In the summer of 2003, one of Susan's physicians, Dr. Amadeo Marcos, advised her that she needed a liver transplant due to the progression of her AATD. Because Susan was not a candidate for a cadaver liver, her son, Christopher, volunteered to donate a lobe of his liver to his mother.

Christopher underwent an extensive battery of tests performed by Dr. Thomas Shaw-Stiffel, which ultimately showed that he, too, suffered from AATD. This disqualified him from donating a lobe of his liver. Christopher was never informed of the results of the testing. Apparently, neither was the rest of the team. It is unclear where, when, or how the breakdown in communication occurred, but 1 month after the testing was completed, Christopher underwent surgery at University of Pittsburgh Medical Center (UPMC) to donate a lobe of his liver to his mother. The mistake was not discovered until years later.

The Yanakoses sued UPMC and the doctors involved in their care for medical malpractice in 2015, twelve years after the surgery. The trial court granted the defense's motion for judgment on the pleadings based on the 7-year

statute of repose in the Medical Care Availability and Reduction of Error Act (MCARE Act), 40 Penn. Stat. §§ 1303.101-1303.910. The Superior Court affirmed the trial court's judgment. This appeal to the Supreme Court of Pennsylvania was taken.

ISSUE:

Does the MCARE 7-year statute of repose violate the “open courts” clause of the Pennsylvania state constitution?

ANALYSIS:

Article I, Section 11, of the Pennsylvania constitution states, in pertinent part: “All courts shall be open; and every man for an injury done him in his lands, goods, person or reputation shall have remedy by due course of law, and right and justice administered without sale, denial or delay.” MCARE, on the other hand, provides that “no cause of action asserting a medical professional liability claim may be commenced after seven years from the date of the alleged tort or breach of contract.” 40 Penn. Stat. § 1303.513(a). However, the period of repose does not apply to claims involving foreign bodies unintentionally left in a patient's body (40 Penn. Stat. § 1303.513(b)) or to injuries to minors until they reach the age of 20 years (40 Penn. Stat. § 1303.513(c)).

The court applied an “intermediate scrutiny” analysis to the statute. This means that the statute “must be substantially or closely related to an important governmental interest.” The court found that the goal of the statute of repose was to control medical malpractice premium rates “by providing actuarial certainty.” The court noted that the legislature did not find any facts to demonstrate (1) how many medical malpractice suits are brought more than 7 years after the incident, (2) what statistical analysis the legislature used to show that 7 years was a practical solution, or (3) how the statute of repose would provide actuarial certainty in the medical malpractice insurance industry. The court noted that “the statute permits malpractice victims who discover their injury and its cause within seven years, foreign objects plaintiffs, and minors to exercise their constitutional right to a remedy; on the other hand, the statute deprives malpractice victims who do not discover their injury or its cause within seven years of their right to a remedy.”

In the final analysis, the court found that the statute impermissibly discriminated between classes of plaintiffs, and there was no valid reason for it to do so. It reversed the judgment of the trial court and remanded the matter for further consideration.

RISK MANAGEMENT CONSIDERATIONS:

A statute of repose is different than a statute of limitations in that it sets a hard cap on the period of time in which a defendant is exposed to liability. The Pennsylvania statute

of repose began to run when the negligence occurred, not when the plaintiffs discovered it. All states have a statute of limitations; not all states have a statute of repose. While statutes of repose are a boon to defendants with long tail exposure, such as manufacturers, architects, and health care providers, they are frowned upon by the courts. They act in derogation of the common law and, as in this case, are contrary to an “open courts” clause in state constitutions (there is no analogous provision in the US Constitution). According to this court, 39 states had “open courts” clauses in their constitutions as of 1992.

The foregoing means that health care providers and facilities in states with statutes of repose need to be wary when relying on them. Pennsylvania is by no means the first state to find a statute of repose unconstitutional. See, for example, *DeYoung v. Providence Medical Center*, 136 Wash. 2d 136 (Wash. 1998). Other statutes of repose have been found to be subject to tolling for equitable estoppel (eg, running out the statute of repose while purporting to negotiate a resolution). *Bullington v. Precise*, No. 16–16715 (11th Cir. August 17, 2017). Connecticut found an exception to its statute of repose for a continuing course of treatment. *Cefaratti v. Aranow*, 321 Conn. 637, 138 A.3d 837 (Conn. 2016). In short, it is not safe to rely on these protections.

There are activities that hinge on the operation of a statute of limitations or repose. The primary one is the length of the retention period for medical records. Records should be retained for a reasonable period, without regard to the statute of repose. The same is true for evidence of potential negligence, such as medication containers, fractured prostheses, biopsy slides, fetal monitor tracings, or other tangible evidence (the stuff that every risk management department has in a cabinet somewhere). If a facility is under a duty to retain something, such as records or evidence, it may be guilty of spoliation if it does not retain it.

Yanakos v. UPMC, No. 10 WAP 2018 (Pa. October 31, 2019)

MEDICAL MALPRACTICE

Nurse practitioner liable for failure to educate patient on risks of condition

FACTS:

Kevin Clanton was seen by Nurse Practitioner (NP) Denise Jordan after he failed a preemployment physical examination due to his high blood pressure. When she examined Mr. Clanton, her diagnoses were hypertension and obesity. She prescribed medication for his blood pressure and scheduled a repeat visit in 1 week. Mr. Clanton did not return in a week as scheduled. Indeed, he waited 2 years to return, and that was after he failed another preemployment physical due to his blood pressure.

During the 2 years that followed the resumption of visits, Mr. Clanton returned to NP Jordan for care 10 times. Mr. Clanton often went long stretches without returning to see NP Jordan, and he failed to take his prescribed medicine if he was not feeling sick. NP Jordan never explained to him why it was important for him to take his medications and that he must attend all appointments, even if he was feeling fine. In fact, NP Jordan never educated Mr. Clanton about hypertension, its associated risks, or the factors that increased the risks for Mr. Clanton in particular. Approximately 3 years after the resumption of his visits, NP Jordan ordered laboratory work on Mr. Clanton, but then, apparently either did not review it or did not act on it. It showed that Mr. Clanton was suffering from early stage kidney disease. One and a half years later, Mr. Clanton was diagnosed with end-stage kidney disease. He was started on hemodialysis and underwent a kidney transplant.

Mr. Clanton brought suit against NP Jordan, who was employed by the US Public Health Service, so the suit was brought against the United States. Following a bench trial in federal district court, the court awarded Mr. Clanton \$30 million in damages. The government appealed the award to the US Court of Appeals for the Seventh Circuit.

ISSUE:

May a provider be held liable for failing to adequately inform a patient about the need to control his/her condition?

ANALYSIS:

This is basically a comparative negligence case, and the trial court found that Mr. Clanton had not been negligent in bringing about the outcome that occurred. In other words, NP Jordan was completely at fault, and Mr. Clanton was not at fault at all. The appellate court noted that the trial court focused on Mr. Clanton's understanding of the need for treatment. The court held that this is not the correct test. The test is not what Mr. Clanton knew or understood. The test is: What would a reasonably prudent person in the same or similar circumstances do, or not do, to avoid the outcome that occurred?

While it may appear, at first blush, that the trial court is simply going to come to the same conclusion on remand, such should not be the case. The court of appeals held that the trial court should reweigh the evidence under the reasonable person standard and it may come to a different conclusion. For example, would the fact that he had failed two preemployment physical examinations because of his blood pressure cause a reasonable person to believe that he should do more to control his blood pressure? While the blood pressures were not revealed in this decision, one would assume that they were extremely high since they warranted disqualification for employment. This may disprove the theory that Mr. Clanton bore no

responsibility for his injury. It may not avoid all liability on NP Jordan's part, but it certainly may reduce it.

The court of appeals reversed the verdict of the trial court and remanded the case for further consideration.

RISK MANAGEMENT CONSIDERATIONS:

It may be said, without fear of contradiction, that noncompliant patients with chronic conditions are the bane of a health care provider's practice. This case shows why that is. There may be many providers for whom this scenario is their worst nightmare. Many providers will terminate non-compliant patients from their practices for fear of liability such as this. However, rather than simply terminating patients who require care and will suffer injury if they do not get it, there may be other possible solutions to this conundrum. These people need care; they just don't appreciate how much they need it. Termination is always a possibility, but there may be other steps that can be taken before that step is taken.

All practices have issues with noncompliant patients with acute or chronic conditions, whether it is an internal/family medicine, OB/GYN, oncology, psychiatry, or other type of practice. The first step is to prioritize patient conditions for risk of injury due to noncompliance. Which conditions commonly seen in the practice will cause serious injury if left untreated or unmanaged? Common high-risk conditions include hypertension, diabetes, obesity, heart disease, cancer, and many more. If the common conditions that will cause injury if untreated are identified, strategies to reduce the risks can be developed.

The second step is to develop a strategy to deal with these patients. For example, are there stock educational materials that can be shown or given to the patient? If the patient watches a video on his/her condition, this should be documented in the chart. If handout materials are provided to the patient, can these be scanned into the chart or otherwise carefully documented in the chart? There are two rationales for taking this step: (1) to inform the patient that there are risks associated with noncompliance; and (2) to prove to the reasonable person who will find the facts at trial (usually a jury) that a reasonable person in the patient's position would not have disregarded this advice.

Once a patient has been determined to be, or to potentially be, noncompliant, the provider should be more specific. This may include a heart-to-heart talk with the patient to see what obstacles to compliance exist for the patient (eg, he or she cannot afford the medication(s), there are undesirable side effects of the medication, etc.). If these can be overcome (eg, switching to a lower-cost generic drug, switching to a different drug with fewer side effects, etc.), all avenues should be explored. If there are no readily surmountable obstacles to compliance, the risks of noncompliance should be carefully described and not be

minimized. Using hypertension as an example, the provider might say: “High blood pressure is a serious condition that could kill you if you don’t manage it. It can cause heart disease, kidney failure, and stroke, just to name the more common problems. It is not good enough to take your medicine when you feel sick, because high blood pressure will not make you feel sick until it is too late. You have to take your medications as prescribed for them to be effective.”

In the final analysis, all adults with decision-making capacity have the right to refuse any and all treatment. However, this refusal must be an informed one. The attempts to inform should be sufficient that no reasonable person, in the patient’s shoes, would continue to refuse. If the patient does continue to be noncompliant, it may be necessary to terminate the patient from the practice. This should be done by registered or certified letter, return receipt requested, according to the provider’s practice, that again spells out the risks of noncompliance and advises the patient that the practice can no longer safely treat him or her. The letter and the return receipt should be scanned into the medical record.

It is recognized that this may be a lot of trouble for a busy provider to undertake. However, when weighed against potential liability of \$30 million, it may be a reasonable use of time and resources.

Clanton v. U.S., No. 18–3060 (7th Cir. November 7, 2019)

MEDICAL MALPRACTICE

Discharge against medical advice terminates hospital’s duty of care

FACTS:

Misty Kruse underwent a cholecystectomy in July 2009 at Raleigh General Hospital (RGH). She was discharged, apparently without incident, after the procedure. A few days later, she was readmitted to RGH and underwent an endoscopic retrograde cholangiopancreatography (ERCP) performed by Dr. Touraj Farid. Subsequent to the ERCP, Ms. Kruse signed herself out of the hospital against medical advice (AMA). She signed a form, which provided:

I, Kruse, Misty, a patient in Raleigh General Hospital of Beckley have determined that I am leaving the hospital and I acknowledge and understand this action of so leaving the hospital is against the advice of the attending physician and of hospital authorities.

I further acknowledge that I have been informed of the possible dangers and risks to my health and the health of others by my so leaving the hospital at this time, and I have been given full explanation of the consequences of my leaving the hospital and I do not wish any further explanation.

I assume the risk and accept the consequences of my departure from Raleigh General Hospital at the time and hereby release all health care providers, including the hospital and its staff, from all liability and responsibility for the ill effects that may result to myself, my family and to others resulting from this discontinuance of treatment in the hospital.

I have read and fully understand this document, and understand the risk and benefits of leaving Against Medical Advice.

Dr. Farid had apparently not been in to see Ms. Kruse prior to her discharge AMA. It is not clear what or whether any specific risks of leaving AMA were explained to her by the nurses who obtained her signature. Dr. Farid later testified that it was his custom to see patients after they have had an ERCP and explain to them that the stents that he implanted were temporary and would need to be removed in a few weeks or months. He would also arrange for follow-up care at that time. Since she left before he saw her, this was not conveyed by Dr. Farid or anyone else to Ms. Kruse. It appears that no attempt was made to relay this information to her after her discharge.

In December 2013, Ms. Kruse was admitted to another hospital in acute distress. It was discovered that the stents, which had never been removed, were blocked. Ms. Kruse was diagnosed with an infection of the biliary tree, ascending cholangitis, and sepsis. She required stent removal, a period of time on a ventilator, and intensive antibiotic treatment to recover. Any residual sequelae from this incident were not disclosed in this opinion.

Ms. Kruse filed suit against Dr. Farid for failing to inform her that the stents were temporary and would need to be removed, and that he failed to provide appropriate follow-up care. Dr. Farid defended on the grounds that Ms. Kruse’s discharge AMA terminated the physician–patient relationship between them and that he had no further duty to Ms. Kruse. The trial court agreed with Dr. Farid and granted his motion for summary judgment. Ms. Kruse took this appeal to the Supreme Court of West Virginia.

ISSUE:

When Ms. Kruse signed the AMA form, did she terminate the physician–patient relationship between herself and Dr. Farid? Did she also release Dr. Farid from future liability by signing the form?

ANALYSIS:

Ms. Kruse argued that summary judgment was improper in this case because there were genuine issues of material fact in this case, including whether she understood that she was signing out AMA (she alleged that she just thought that she was being discharged). The court noted the general rule that once a competent party signs a document she is bound by the terms of the document. In this case,

there was no reason to believe that Ms. Kruse was misled regarding the import of the AMA form. The court found that this did not create an issue of material fact.

The court also noted that there were two potential duties of care in this case: the duty of care *before* the discharge and the duty of care *after* the discharge. The court noted that Ms. Kruse really objected only to the care provided after the discharge, thus concluding that she waived any claim she may have had regarding care before her AMA discharge. The court found that her discharge terminated the provider–patient relationship with both the hospital and Dr. Farid.

With respect to the issue of the release, the court held that, in West Virginia, the law requires that a release must release a right that is secured by statute. In this case, that statute is the West Virginia Medical Professional Liability Act, W. Va. Code §§ 55–7B-1 to -12, which protects *patients* from negligent acts or omissions performed by providers. The court noted that when Ms. Kruse discharged herself against medical advice, she was no longer a patient of either Dr. Farid or RGH. Because she was no longer a patient, the release was valid.

Accordingly, the Supreme Court affirmed the dismissal of Ms. Kruse’s claim.

RISK MANAGEMENT CONSIDERATIONS:

A search of the Internet revealed that Dr. Farid is a gastroenterologist and is affiliated in some way with RGH. It is most likely that he did not perform the cholecystectomy. It is not clear whether he is employed by RGH. It is not clear from this decision what Dr. Farid’s relationship with Ms. Kruse was. There are three possibilities: (1) Dr. Farid is an independent medical staff member with privileges at RGH who formed a relationship with Ms. Kruse outside the hospital; (2) Dr. Farid is an independent medical staff member with privileges at RGH who formed a relationship with Ms. Kruse as a result of taking call for gastroenterology at RGH; or (3) Dr. Farid is employed by RGH and saw Ms. Kruse as part of his hospital duties. These various roles are important in determining the precedential impact of this case.

If Dr. Farid entered into an extrahospital physician–patient relationship with Ms. Kruse, it is difficult to see how the AMA form terminated that relationship. It is true that Ms. Kruse, by signing the form, did “release all health care providers, including the hospital and its staff...”, but the usual meaning of the word *staff* is “employee.” Had the form meant to include “medical staff members,” it certainly could have so stipulated. Consequently, it is doubtful that the form terminated the relationship between Ms. Kruse and Dr. Farid if he is an independent medical staff member who formed an extrahospital relationship with Ms. Kruse. That relationship could have been terminated by either party by so informing the other party, but it is difficult to

see how the AMA form accomplished this. If this is the correct scenario, it appears that the court conflated the physician–patient relationship with the hospital–patient relationship, which are two different things.

If Dr. Farid is an independent medical staff member who was on call for gastroenterology when Ms. Kruse came in and they formed a relationship that way, the court’s assessment of the situation may be valid. It could be argued that Dr. Farid’s relationship with Ms. Kruse arose out of his agency relationship with RGH and could be terminated by a termination of the hospital–patient relationship, but this writer has never encountered such a scenario or outcome. This scenario is less probable than the employment relationship between Dr. Farid and RGH discussed below.

If Dr. Farid was an employee of the hospital, then it is clear that an argument can be made that the AMA discharge severed his relationship with Ms. Kruse, just as it severed her relationship with the nurses who were caring for her. It is not an open-and-shut case because the physician–patient relationship is far more complex than the nurse–patient relationship, but the argument may nonetheless be made. It is noteworthy, however, that Ms. Kruse apparently did not sue RGH. If there was an employer–employee relationship between RGH and Dr. Farid, one would expect his employer to also be named in the suit, even if only to add another “deep pocket.” This does not mean that an employment relationship does not exist, but it militates against such a finding.

Regardless of the relationships between Dr. Farid and Ms. Kruse and RGH, this discharge was handled exceptionally poorly. An AMA discharge is still a discharge, and it would appear that Centers for Medicare & Medicaid Services (CMS) regulations would cover it. They provide that:

Hospital discharge planning is a process that involves determining the appropriate post hospital discharge destination for a patient; identifying what the patient requires for a smooth and safe transition from the hospital to his/her discharge destination; and beginning the process of meeting the patient’s identified post-discharge needs. (CMS Conditions of Participation for Hospitals, Interpretive Guidelines, 42 CFR § 482.43).

Unfortunately, many hospitals assume that they may safely dispose of their obligations to make a discharge “safe” by having the patient sign a piece of paper.

Whether or not Dr. Farid had a continuing obligation to Ms. Kruse under West Virginia law, he had an ethical obligation to provide her with appropriate discharge instructions and terminate their relationship appropriately so that she could get the follow-up care she needed. This may have required Dr. Farid to call her to advise her of the situation. This case may have been a fluke caused by technicalities of West Virginia law when applied to the

particular facts of this case, and another provider may not have the same outcome. If one must speculate about the facts of a case, it should be a clarion call to be careful in attempting to follow it. This is not a case upon which hospitals in West Virginia or elsewhere should rely.

To be legally and ethically sound, a discharge AMA should really be an informed refusal of further hospital care. It is not, as this court seems to believe, a refusal of further medical care; rather, it is only a refusal of further in-patient hospital care. The patient should be informed of the risks of leaving prematurely, the benefits of receiving further care, and any alternatives to continued in-patient care. If the person who is most familiar with the risks of leaving is the admitting physician, then he or she should be called to consult with the patient, if at all possible. As this case clearly demonstrates, bad things happen when patients do

not appreciate the risks of leaving AMA and the need for follow-up care.

It is potentially perilous to take a cavalier attitude toward AMA discharges. They should still be made as safely as they possibly can be.

Kruse v. Farid, No. 18–0464 (W. Va. November 8, 2019)

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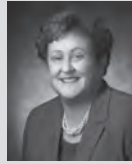
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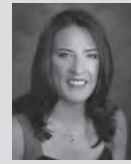
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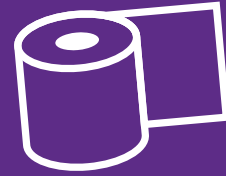
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