Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the Case of:	)	
	)	
The Inspector General,	)	Date: May 23, 1997
	)	
- v. -	)	
	)	
Theodore Cherukuri, M.D.,	)	Docket No. C-96-020
	)	Decision No. CR475
Respondent.	)	
	)	

DECISION

The case before me arose pursuant to the notice letter issued on September 20, 1995, by the Inspector General (I.G.) of the Department of Health and Human Services. The notice letter informed Dr. Theodore Cherukuri (Respondent) of the I.G.'s determination that Respondent had committed two violations of section 1867 of the Social Security Act (Act) on September 15, 1991, with respect to the care and transfer of two patients who were presented to the emergency room of Williamson Appalachian Regional Hospital (ARH) in South Williamson, Kentucky. The I.G. notified Respondent also that she was proposing to impose against him two civil money penalties (CMP) in the amount of $50,000 for each violation, and to exclude Respondent for a period of two years from participation in the Medicare program and various federally funded state health care programs under the Act.[1] Respondent filed a timely challenge to the I.G.'s determinations and proposed actions.

[1] I will use the abbreviation of "Medicaid" to designate those State health care programs to which the I.G.'s notice references.

I held an in-person hearing for four days in Huntington, West Virginia, and later received rebuttal testimony and evidence by telephone on two additional days.[2] The parties have also submitted post-hearing briefs.[3]

For the reasons which follow, I uphold the I.G.'s proposal to impose a CMP of $50,000 for each of the two violations specified by the I.G. However, I set aside the exclusion of two years proposed also by the I.G.

APPLICABLE STATUTES AND REGULATIONS

Section 1867 of the Act specifies certain special responsibilities placed on those individuals who work at or for hospitals which have emergency rooms and which

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[2] The parties did not move for the correction of any transcription errors. However, I note that nearly all of the transcript pages (Tr.) for the two days of telephone testimony were assigned page numbers which duplicate those for the last day of the in-person hearing. To remedy the duplicate page numbers, I am now causing the abbreviation **"T"** to be affixed to the original transcript pages for all telephone testimony of July 29 and September 12, 1996.

In addition, I raise on my own motion the need to correct for the record the identification of certain exhibits discussed on September 12, 1996. As reflected at Tr. 1002**T** - 1004**T**, I received into evidence only the last two pages of a document which was generated by Dr. William Aaron and offered by Respondent. Because this document had been identified by Respondent as his exhibit (Ex.) 7 in its entirety during the hearing, my ruling on its admissibility was done in accordance with said numerical designation. Tr. 1002**T** - 1004**T**. However, Respondent later offered a different document (a letter from the West Virginia licensure board) also marked as his proposed Ex. 7 (Tr. 1039**T**), and I rejected the admission of this document based on the same numerical designation (Tr. 1041**T**). To correct the foregoing errors, I am causing the latter document, i.e., the letter from the West Virginia licensure board, to be remarked as Respondent's proposed Ex. 8. The contents of the relevant transcript pages (Tr. 1039**T**, 1041**T**), as well as the index page (Tr. 961**T**), have been corrected to conform to the revision.

[3] The I.G.'s main post-hearing brief will be referenced as "I.G. Br.," and her reply brief as "I.G. Reply." The corresponding briefs submitted by Respondent will be referenced as "R. Br." and "R. Reply."

participate in the Medicare program.[4] These responsibilities are triggered whenever an individual (whether or not a Medicare beneficiary) comes to a participating hospital's emergency room and a request for medical treatment is made by that individual or on that individual's behalf. Section 1867(a) of the Act. At that point, the hospital must provide an appropriate medical screening examination to determine whether the individual has an emergency medical condition. Section 1867(a) of the Act; see 42 C.F.R. § 489.24(a).

Subsections (b) through (e) of section 1867 of the Act specify those additional responsibilities and definitions which are relevant to this case. The regulations implementing these relevant statutory subsections are codified at 42 C.F.R. § 489.24 and 42 C.F.R. Part 1003.

Subsection (b) of section 1867, titled **"Necessary Stabilizing Treatment for Emergency Medical Conditions and Labor,"** specifies that if a participating hospital with an emergency department determines that the individual has an emergency medical condition, the hospital must provide either:

> (A) within the staff and facilities available at the hospital, for such further medical examination and such treatment as may be required to stabilize the medical condition, or
>
> (B) for transfer of the individual to another medical facility in accordance with subsection (c) [titled "Restricting Transfers Until Individual Stabilized"].

Section 1867(b)(1) of the Act; see 42 C.F.R. § 489.24(c).

An "emergency medical condition" means:

> (A) a medical condition manifesting itself by acute symptoms of sufficient severity . . . such that the absence of immediate medical attention could reasonably be expected to result in --
>
> > (i) placing the health of the individual . . . in serious jeopardy,
> >
> > (ii) serious impairment to bodily functions, or

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[4] A hospital participating in the Medicare program is defined as a "participating hospital." Section 1867(e)(2) of the Act.

> (iii) serious dysfunction of any bodily organ or part.

Section 1867(e)(1)(A) of the Act; see 42 C.F.R. § 498.24(b).

"To stabilize" means, with respect to any emergency medical condition described in section 1867(e)(1)(A):

> To provide such medical 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 . . .

Section 1867(e)(3)(A) of the Act; see 42 C.F.R. § 489.24(b).

"A transfer" means:

> The movement . . . of an individual outside a hospital's facilities at the direction of any person employed by (or affiliated or associated directly or indirectly, with) the hospital . . .

Section 1867(e)(4) of the Act[5]; see 42 C.F.R. § 489.24(b) (emphasis added).

The hospital is deemed to have met its obligations to stabilize the medical condition under section 1867(b)(1) of the Act if the individual, or a person acting on the individual's behalf, refuses to consent to such stabilization treatment after being informed of the risks and benefits to the individual of such treatment. Section 1867(b)(2); see 42 C.F.R. § 489.24(c)(2). However, the hospital must take all reasonable steps to secure the individual's (or responsible person's) written, informed refusal of such treatment. Id. The medical records should contain a description of the examination or treatment refused by or on behalf of the individual. 42 C.F.R. § 489.24(c)(2).

Subsection (c) of section 1867, titled **"Restricting Transfers Until Individual Stabilized,"** prohibits a hospital from transferring an individual with a medical condition that has

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[5] The definition of "transfer" excludes movements where the individual has been declared dead or has left the facility without the permission of those employed by or associated with the hospital. 42 C.F.R. § 489.24(b).

not been stabilized within the meaning of section 1867(e)(3)(B) of the Act, unless,

> (A)(i) the individual (or a legally responsible person acting on the individual's behalf) after being informed of the hospital's obligations under this section and of the risk of transfer, in writing requests transfer to another medical facility,
>
> > (ii) a physician . . . has signed a certification that based upon the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual . . ., or
> >
> > (iii) if a physician is not physically present in the emergency department at the time an individual is transferred, a qualified medical person (as defined by the Secretary [of the Department of Health and Human Services] in regulations[6]) has signed a certification described in clause (ii) after a physician . . ., in consultation with the person, has made the determination described in such clause, and subsequently countersigns the certification; and
>
> (B) the transfer is an appropriate transfer . . . .

Section 1867(c)(1)(A) and (B) of the Act; see 42 C.F.R. § 489.24(d).

The certification specified in (ii) and (iii) of paragraph A, above, must include a summary of the risks and benefits upon which the certification is based. Section 1867(c)(1) of the Act; see 42 C.F.R. § 489.24(d)(1)(ii)(B) and (C).

The term "stabilized" means:

> with respect to an emergency medical condition . . ., that no material deterioration of the condition is likely, within reasonable medical probability,

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[6] The Secretary's regulations define "a qualified medical person" as one so determined by the hospital in accordance with its bylaws or rules and regulations. 42 C.F.R. § 489.24(d)(1)(ii)(C).

> to result from or occur during the transfer of the individual from a facility . . . .

Section 1867(e)(3)(B) of the Act.

The "appropriate transfer" mandated by section 1867(c)(1)(B) of the Act means, as relevant to this case, a transfer:

> (A) in which the transferring hospital provides the medical treatment within its capacity which minimizes the risks to the individual's health . . ., and
>
> (B) in which the receiving facility --
>
> > (i) has available space and qualified personnel for the treatment of the individual, and
> >
> > (ii) has agreed to accept transfer of the individual and to provide appropriate medical treatment; [and]
>
> (C) in which the transferring hospital sends to the receiving facility all medical records . . . related to the emergency condition for which the individual has presented . . . including . . . the name and address of any on-call physician (described in subsection (d)(1)(C)) who has refused or failed to appear within a reasonable time to provide necessary stabilizing treatment; [and]
>
> (D) in which the transfer is effected through qualified personnel and transportation equipment, as required . . . .

Section 1867(c)(2)(A) - (D); see 42 C.F.R. § 489.24(d).

Subsection (d) of section 1867, titled **"Enforcement,"** specifies that a hospital is subject to a CMP if it negligently violates one or more of the requirements described above. Section 1867(d)(1)(A) of the Act. In addition, subsection (d) also authorizes the imposition of sanctions against:

> any physician who is responsible for the examination, treatment, or transfer of an individual in a participating hospital, including a physician on-call for the care of such an individual, and who negligently violates a requirement of this section . . .

Section 1867(d)(1)(B) of the Act; see 42 C.F.R. § 1003.101.

However, a physician's liability specified in section 1867(d)(1)(B) is subject to the following caveat:

> If, after an initial examination, a physician determines that the individual requires the services of a physician listed by the hospital on its list of on-call physicians . . . and notifies the on-call physician and the on-call physician fails or refuses to appear within a reasonable period of time, and the physician orders the transfer of the individual because the physician determines that without the services of the on-call physician the benefits of transfer outweigh the risks of transfer, the physician authorizing the transfer shall not be subject to a penalty under subparagraph (B) [of section 1867(d)(1)]. However, the previous sentence shall not apply to the hospital or to the on-call physician who failed or refused to appear.

Section 1867(d)(1)(C) of the Act.

Any physician who negligently violates a requirement of section 1867 is subject to a CMP of not more than $50,000 for each such violation. Section 1867(d)(1)(B) of the Act; see 42 C.F.R. §§ 1003.102(c)(1)(ii), 1003.103(e)(2)(iii). The I.G. has been delegated the authority for imposing a penalty under section 1867 of the Act against any responsible physician who has negligently violated the statutory requirements on or after May 1, 1991. 42 C.F.R. § 1003.102(c)(1)(ii).

In determining the amount of a CMP, the I.G. is required to consider the following factors:

> -- the degree of a respondent's culpability,
>
> -- the seriousness of the condition of the individual seeking emergency medical treatment,
>
> -- any prior history of a respondent's offenses,
>
> -- a respondent's financial condition,
>
> -- the nature and circumstances of the violation, and
>
> -- such other matters as justice may require.

42 C.F.R. § 1003.106(a)(4).

In addition to having a CMP imposed against him, a physician may also be excluded from participation in the Medicare and State health care programs for any gross and flagrant or

repeated violations of the statute's requirements. Section 1867(d)(1)(B) of the Act; see 42 C.F.R. § 1003.105(a)(1). A "gross and flagrant" violation is one which:

> presents an imminent danger to the health, safety or well-being of the individual who seeks emergency examination and treatment or places that individual unnecessarily in a high risk situation.

42 C.F.R. § 1003.105(a)(1)(C). The I.G. has been delegated the authority for imposing and directing an exclusion against any person for a gross and flagrant or repeated violation of section 1867 occurring on or after May 1, 1991. 42 C.F.R. § 1003.105(a)(1)(ii)(C).

DISCUSSION

Section I

In this section, I discuss my reasons for having reached the following findings of fact and conclusions of law (FFCLs) with respect to the relevant events which occurred at ARH, a Medicare participating hospital with an emergency room, on September 15, 1991[7]:

> **1. At or shortly before 3:30 AM, requests for treatment were made on behalf of Sean Crum and Delmar Mills to ARH's emergency room, within the meaning of section 1867(a) of the Act.**
>
> **2. ARH's emergency room was staffed by Pedro Hani, M.D., and Judy Hatfield, R.N.**
>
> **3. Pat White, R.N., ARH's "house supervisor," was called in especially to the emergency room to give assistance.**
>
> **4. Respondent was the on-call surgeon summoned by ARH for the evaluation or care of Sean Crum and Delmar Mills.**
>
> **5. Respondent arrived at ARH at about 3:45 AM in order to evaluate or care for Sean Crum and Delmar Mills.**

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[7] Unless I indicate otherwise, all of the facts discussed herein will relate to the events of September 15, 1991 and the patients named Sean Crum and Delmar Mills.

In addition, unless I note otherwise, words such as "stable," "stabilize," "transfer," and "gross and flagrant" used in this decision will have the meaning specified by the statutes and regulations cited above.

6. The medical screening procedures performed by ARH's emergency room staff and its on-call surgeon (Respondent) established that Sean Crum and Delmar Mills each had an emergency medical condition within the meaning of section 1867(e)(1) of the Act.

7. Under section 1867(b) of the Act, Sean Crum and Delmar Mills were entitled to receive at ARH either such further medical treatment as might be required to stabilize their emergency medical condition, or to have ARH transfer them to another medical facility in accordance with the additional statutory requirements specified in and incorporated by section 1867(c) of the Act.

8. As of 4:00 AM, the emergency medical conditions of Sean Crum and Delmar Mills were not "stable," as defined by section 1867(e)(3)(A) of the Act.

9. As of 4:00 AM, Respondent knew that abdominal surgery (i.e., an exploratory laparotomy) was the necessary and appropriate treatment to stabilize Sean Crum's emergency medical condition.

10. As of 4:00 AM, Respondent knew that abdominal surgery (i.e., an exploratory laparotomy) was the necessary and appropriate treatment to stabilize Delmar Mill's emergency medical condition.

11. Respondent did not perform abdominal surgery on either Sean Crum or Delmar Mills.

12. At 4:00 AM, Respondent wrote his determination in the medical charts of Sean Crum and Delmar Mills that these two patients should be transferred immediately.

There is no dispute that an automobile accident occurred near South Williamson, Kentucky, during the early morning of September 15, 1991. Tr. 477, 538. A total of five people riding in two cars incurred injuries of varying degrees as a result of the accident. E.g., Tr. 380. These five accident victims, including Delmar Mills and Sean Crum, were transported to ARH, an area hospital which was participating in the Medicare program and which had an emergency room. E.g., Tr. 380, 478, 538 - 40. Both Delmar Mills and Sean Crum were then admitted to ARH's emergency room by 3:30 AM. I.G. Ex. 2 at 2; I.G. Ex. 3 at 5.

The condition of these two patients was deemed "critical"[8] when they were brought to ARH by ambulance, and both were placed into emergency room beds designated for critically ill patients. I.G. Ex. 4 at 3; Tr. 479. Sean Crum was noted by the emergency room staff to have various problems, including being unresponsive to pain or command, having dilated pupils, having shallow respiration, and having blood coming out of both ears. I.G. Ex. 4 at 3. Delmar Mills was noted by the emergency room staff to have problems which included giving inappropriate responses, having a blood pressure of 68/50, and having a distended abdomen. Id.

On the morning of September 15, 1991, ARH's emergency room was staffed by Pedro Hani, M.D., and Judy Hatfield, R.N. Tr. 538. Pat White, R.N., was the relief supervisor or house supervisor for ARH during that morning. Tr. 476. In that capacity, she was in charge of the entire hospital, including the emergency room. Tr. 476 - 77. She was called to the emergency room to lend assistance when the five accident victims began arriving. Tr. 478.

At Dr. Hani's request, Pat White summoned the on-call surgeon[9] to ARH's emergency room in order to evaluate Sean Crum and Delmar Mills. HCFA Ex. 2 at 3; Tr. 478. Respondent was the surgeon on call that morning. Tr. 478. Even though it cannot be ascertained precisely when Respondent arrived at the emergency room to begin his evaluation of Delmar Mills and Sean Crum, it is most likely that Respondent arrived at about 3:45 AM.[10]

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[8] "Critical" means "pertaining to or of the nature of a crisis; in danger of death...." Dorland's Illustrated Medical Dictionary (27th ed.).

[9] At ARH, the on-call schedule for physicians of each medical specialty was established by the physicians and their departments. Tr. 982T. The administrative staff at ARH receives and distributes these on-call lists. Id. The physicians on the list are contacted in order, and on a rotating basis, to provide coverage during those hours when most physicians are at home. Tr. 982T - 83T.

[10] Delmar Mills and Sean Crum were admitted to the emergency room at 3:12 AM and 3:30 AM, respectively. I.G. Ex. 2 at 2; I.G. Ex. 3 at 5. Respondent said that Pat White called him around 3:15 AM and that he arrived at the hospital just before 3:30 AM. Tr. 840 - 41. Respondent wrote "3:45" as the time he began documenting his observations of Sean Crum's condition. I.G. Ex. 3 at 2.

However, according to an entry in Sean Crum's nursing care records, 3:30 AM was when Respondent was first contacted.

(continued...)

For Sean Crum, Respondent noted at 3:45 AM that the patient had multiple trauma (chest trauma and abdominal trauma), was bleeding from both his ears and his nose, and was in a deep coma with dilated pupils. I.G. Ex. 3 at 2. For Delmar Mills, Respondent noted at 4:00 AM that the patient had a head injury, had abdominal trauma, and was bleeding from the right ear. I.G. Ex. 2 at 17. Respondent wrote the foregoing notes after having performed a procedure called a peritoneal tap on each patient. I.G. Ex. 3 at 2; I.G. Ex. 2 at 17.

A peritoneal tap (also called a peritoneal lavage) is usually performed by a surgeon when abdominal trauma is suspected. Tr. 41 - 43. The purpose is to determine whether there is, in fact, bleeding occurring in the abdominal cavity. Tr. 129. The procedure involves making a small incision in the abdomen, passing a catheter into the abdominal cavity, and drawing fluid out to ascertain whether blood is present. Tr. 42, 129. If a certain amount of red blood cells are present in the liquid that is drawn out, then it means that some organ in the abdomen has been injured, and the result is considered positive. Id. In the case of Sean Crum and Delmar Mills, Respondent was aware by 3:45 AM and 4:00 AM, respectively, that the peritoneal taps done on these two patients were positive for abdominal bleeding. I.G. Ex. 3 at 2; I.G. Ex. 2 at 17.

Medical experts are in agreement that, even though both Sean Crum and Delmar Mills had head injuries as well as abdominal injuries, well established protocol in emergency medicine dictates that abdominal surgery should be performed pursuant to positive peritoneal tap results in advance of treating patients for head injuries. Tr. 45 - 46, 64 - 65, 130 - 31, 302, 356, 415. Under the so-called "ABC" protocol, physicians should treat any multiply injured patient by first clearing their airway ("A"), correcting their breathing problems ("B"), and correcting their circulation problems ("C"), in order to sustain the patient's life with adequate oxygen intake and blood circulation before proceeding to any other treatment. Tr. 45 - 46, 64 - 65. On-going bleeding in the abdomen could result in further injuries to other organs in the body, or it could result in death. Tr. 47.

Therefore, for Sean Crum and Delmar Mills, at approximately 4:00 AM on September 15, 1991, the appropriate next step under the "ABC" protocol should have been exploratory laparotomy, a procedure where the surgeon makes an incision along the abdomen in order to assess the various organs in

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[10](...continued)
I.G. Ex. 3 at 5. According to an entry in Delmar Mill's nursing care records, 4:00 AM was recorded as the time of Respondent's arrival. I.G. Ex. 2 at 11.

the abdomen and to suture or otherwise stop the bleeding. Tr. 44, 130, 415.

The notes made by Respondent in the two patients' charts, at 3:45 AM for Sean Crum and at 4:00 AM for Delmar Mills, established Respondent's awareness that, following their positive peritoneal lavage results, he should perform exploratory laparotomy forthwith to control each of these two patients' abdominal bleeding. I.G. Ex. 3 at 2; I.G. Ex. 2 at 17. Respondent testified that, even though Sean Crum had sustained severe brain injury, blood circulation to his brain must still be maintained in order to keep him alive. Tr. 846. Respondent said he knew that abdominal surgery was necessary and appropriate for both patients, that abdominal surgery should have been done as soon as possible, and that abdominal surgery should be done before any treatment of head injuries. Tr. 894. Respondent testified also that he had decided to perform abdominal surgery on both patients immediately, at approximately 4:00 AM on September 15, 1991 (Tr. 849, 853), after having established a diagnosis of internal injuries with the use of peritoneal taps in the first 15 minutes (Tr. 848).

The foregoing facts leave no doubt that requests for treatment were made on behalf of both Sean Crum and Delmar Mills, within the meaning of section 1867(a) of the Act, when they were taken by ambulance to ARH's emergency room sometime after 3:00 AM on September 15, 1991.

The undisputed evidence that Respondent was the on-call surgeon summoned to care for Sean Crum and Delmar Mills establishes that Respondent is subject to liability under section 1867(d)(1)(B) for any negligent violations of the statutory requirements.

In addition, the undisputed evidence discussed above establishes that the appropriate medical screening procedures performed by ARH's emergency room staff and its on-call surgeon (Respondent) established that each of these two patients had emergency medical conditions within the meaning of section 1867(e)(1) of the Act. Therefore, Sean Crum and Delmar Mills were entitled to receive at ARH either such further medical treatment as may be required to stabilize their emergency medical condition, or to have ARH transfer them to another medical facility in accordance with the additional requirements of the statute. Section 1867(b) of the Act.

The undisputed evidence discussed above establishes further that, as of 4:00 AM on September 15, 1991, neither of the two patients was in stable condition as defined by section 1867(e)(3)(A) of the Act, and that abdominal surgery (i.e., an exploratory laparotomy) was the necessary and appropriate

medical treatment for the stabilization of these two patients at that time.

There is no dispute that Respondent did not, in fact, perform abdominal surgery on either Sean Crum or Delmar Mills after he found them to be unstable and allegedly decided to perform surgery at 4:00 AM. See Tr. 849, 853. Even though there is a conflict in the evidence as to why he did not perform the exploratory laparotomies he deemed appropriate,[11] the documents generated by Respondent himself show that he wrote in both patients' medical charts at 4:00 AM that both patients should be transferred immediately. I.G. Ex. 2 at 17; I.G. Ex. 3 at 2.

Section II

In this section, I explain my reasons for having found and concluded as follows:

> **13. Respondent led the nurses in ARH's emergency room to believe that St. Mary's Hospital had agreed to accept the transfer of Sean Crum and Delmar Mills.**
>
> **14. It was Respondent's duty as the on-call surgeon to make the transfer decisions for patients in the emergency room who were in need of surgery.**
>
> **15. The transfers of Sean Crum and Delmar Mills from ARH to St. Mary's Hospital were effectuated by Pat White, pursuant to the information and directives given by Respondent.**
>
> **16. With Respondent's authorization, Pat White completed the documents titled "Emergency Services Transfer Record" and placed his name on them.**
>
> **17. Respondent's actions, inactions, and words, at and after 4:00 AM, caused Sean Crum and Delmar Mills to be transferred within the meaning of section 1867(e)(4) of the Act.**
>
> **18. Dr. Hani did not order the transfer of either Sean Crum or Delmar Mills.**

As noted in the preceding section, Respondent did not perform abdominal surgery on either Sean Crum or Delmar Mills after he determined them to be unstable and had allegedly decided to perform such surgery at 4:00 AM. Instead, Respondent wrote in both patients' medical charts at 4:00 AM that both

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[11] I will discuss the conflicting evidence in a later section of this decision.

patients should be transferred immediately. I.G. Ex. 2 at 17; I.G. Ex. 3 at 2.

The evidence introduced by the parties shows that either prior to or after writing the above notes concerning an immediate transfer at 4:00 AM, Respondent telephoned Dr. Sirous Arya, a surgeon who was on call that morning at St. Mary's Hospital in Huntington, West Virginia, to discuss a transfer. I.G. Ex. 10; I.G. Ex. 4 at 3; Tr. 491, 850 - 51. According to Petitioner's testimony, the following was his action after he spoke with Dr. Arya:

> And then I said immediately to the nurses and to Dr. Hani. Prepare for transfer.

Tr. 851.

Pat White testified that she knew only that Respondent had spoken to a physician at St. Mary's Hospital, but that she did not hear the conversation between them. Tr. 521. She testified also that Respondent told the nurses after his phone call to Dr. Arya that Delmar Mills and Sean Crum had been accepted for transfer and to prepare these patients for transport. Tr. 493 - 494, 521.

Judy Hatfield, the only other health care professional who was working in ARH's emergency room that morning in addition to Pat White, Dr. Hani, and Respondent, testified that -- as far as she knew -- Respondent was the one who made the decision to transfer Delmar Mills and Sean Crum. Tr. 560. Judy Hatfield testified also that Respondent was on the telephone with St. Mary's Hospital and then stated that the patients could be transferred there. Tr. 569.

Pat White testified that she prepared the patients for transfer, as directed by Respondent, by readying the proper forms and calling the helicopter transport service. Tr. 494. She testified that when she was told that a helicopter could not land at ARH that morning due to weather conditions, she gave Respondent that information, and Respondent told her to arrange for an ambulance. Tr. 494 - 96. She then arranged for ambulance transportation. Id.

Pat White testified also that she prepared the transfer papers in accordance with Respondent's directives, including placing his name on the transfer forms in spaces requiring a physician's certification of certain information. Tr. 502 - 12; I.G. Ex. 2 at 9 - 10; I.G. Ex. 3 at 9 - 10.

Pat White testified also that Dr. Hani, the emergency room doctor, did not order the transfer of Sean Crum or Delmar Mills. Tr. 517. I find this testimony credible, since it is consistent with the fact that Dr. Hani's name does not appear anywhere on the transfer forms (I.G. Ex. 2 at 9 - 10; I.G.

Ex. 3 at 9 - 10), and is consistent also with Dr. Hani's sworn statement that he refused to sign the transfer forms because he believed that the risks of transfer outweighed the potential benefits. I.G. Ex. 12.[12] Pat White's testimony is consistent also with Respondent's acknowledgement that he told the nurses and Dr. Hani to prepare the patients for transfer immediately following his conversation with Dr. Arya (see Tr. 851) and with the contents of an incident report she prepared for ARH shortly after the transfers at issue had occurred. I.G. Ex. 4 at 3 - 4; Tr. 514 - 15.

In the incident report Pat White prepared shortly after September 15, 1991, she recounted Dr. Hani's refusal to sign the transfer forms when Respondent asked Dr. Hani to do so. I.G. Ex. 4 at 3. According to Pat White's report, Dr. Hani said he was refusing to accept responsibility for the transfer due to the patient's bleeding and unstable condition. Id. Dr. Hani told Respondent that Respondent must sign those transfer forms since Respondent was the referring physician. Id. According to Pat White's report, Respondent gave instructions to prepare the patients for transfer even after Dr. Hani refused to sign the forms. Id at 4.

Pat White said in this report that when she asked Respondent to sign the transfer forms, he told her to sign his name on them and refused to sign them personally. Id. However, testifying at the hearing five years later, she explained that the reason for Respondent's not having signed the transfer forms was not so much that he refused, but that he was busy at the time. Tr. 512, 524. Pat White indicated that she had filled the transfer forms out as best she could, and was told by Respondent to place his initials on them even

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[12] Respondent testified that on ARH's "Emergency Record" sheet for Delmar Mills, Dr. Hani's signature appears on top of Dr. Hani's handwritten comment, "To be transferred to St. Mary's via ambulances, with ARH staff nurse." Tr. 869 (referring to I.G. Ex. 2 at 2). He testified also that on ARH's "Emergency Record" sheet for Delmar Mills, Dr. Hani's signature appears together with comments such as "Transfer by ambulance to Saint Mary's" and "Advance cardiac life support." Tr. 873 - 74 (referring to I.G. Ex. 3 at 18). Respondent's counsel suggested that these were transfer orders issued by Dr. Hani. Tr. 873.

I do not find sufficient proof in support of Respondent's theory. It appears more likely that the foregoing statements were Dr. Hani's summaries of what took place (and not his orders) since the evidence from Dr. Hani and Pat White establishes that Dr. Hani was opposed to the transfers and had refused to sign the transfer forms required by law.

though he had not read their contents. Tr. 524. She described Dr. Hani as not being very cooperative that night. Tr. 497.

I do not find credible Respondent's assertions that he never told Pat White to fill out the transfer forms for either patient and that he was never asked to sign those forms. Tr. 907 - 10. Respondent's assertions conflict with his broad directives to prepare the two patients for transfer to St. Mary's Hospital (Tr. 851; I.G. Ex. 4 at 3 - 4), and with his knowledge that such forms must be filled out in order to transfer patients (Tr. 906). As also pointed out by Dr. Michael Hannigan, one of the physicians called by the I.G. to testify at the hearing, an accepted standard in the medical profession is for the surgeon to make the transfer decision when the service needed by a patient is surgery. Tr. 107.

This professional standard is logically based on the fact that, if a surgeon has determined that a patient needs surgery, then the surgeon must decide whether the surgery should be performed at his own facility, or whether the surgery should be performed by another surgeon at a different facility. Id. Dr. Aaron, one of the experts who testified for Respondent, noted also that Respondent had the qualifications to make a determination as to the patients' surgical stability and was in a position to decide whether the benefits of transfer would outweigh its risks. Tr. 1036T. Dr. Fowler, also an expert who testified for Respondent, was of the opinion that "Respondent stepped in when he didn't have to." Tr. 616. In addition, Respondent was aware that the emergency room staff of ARH would follow directives such as the ones he issued which resulted in the transfers. See Tr. 904 - 05.

I found Pat White more credible than Respondent on the issue of whether Respondent told her to fill out the transfer forms and place his name on them. Not only is her account more consistent with the other evidence of record, she also has less to gain than Respondent by providing inaccurate information on these issues.[13] Moreover, there is nothing of record which makes believable the possibility that an experienced nurse such as Pat White (Tr. 476) would have taken the actions she described to transfer critically injured patients without having received the necessary

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[13] Respondent is at risk for a CMP in the amount of $100,000, as well as a two-year exclusion from participation in the Medicare and Medicaid programs, also imposed against him by the I.G. In contrast, nothing has been assessed against Pat White personally. However, ARH has already paid a fine to the I.G. in settlement of an action brought against ARH and its employees for the very transfers at issue. Tr. 1024T.

directives from Respondent, especially after she heard Dr. Hani state his opposition to the transfers based on the patients' unstable medical conditions.

Section III

In this section, I discuss my reasons for having found and concluded as follows:

> **19. Respondent caused Sean Crum and Delmar Mills to be transferred from ARH to St. Mary's Hospital under the following conditions:**
>
> > **A. without having had any physician sign or countersign a certification in accordance with section 1867(c)(1)(A)(ii) and (iii) of the Act that the physician had in fact evaluated the conditions of the two patients at the time of the transfer to determine whether the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility would outweigh the increased risks to these patients; and**
> >
> > **B. without having secured the agreement of St. Mary's Hospital to accept the transfer of these two patients (see section 1867(c)(2)(B)(ii)).**
>
> **20. Respondent's written "advice" to Dr. Hani does not relieve Respondent of his responsibility for having caused the transfers of Sean Crum and Delmar Mills.**
>
> **21. If any arguably legitimate basis existed for the transfers at issue, Respondent was the physician who should have signed or counter-signed the certification required by section 1867(c)(1)(A)(ii) and (iii) of the Act.**
>
> **22. If any arguably legitimate basis existed for the transfers at issue, Respondent should have contacted St. Mary's Hospital for acceptance instead of writing his "advice" that Dr. Hani should do so.**

For the reasons explained by Pat White, she placed Respondent's name on the transfer forms as the physician who had secured the agreement of the receiving physician and receiving hospital, Dr. Arya and St. Mary's Hospital, respectively, for the transfers in issue. E.g., Tr. 502 - 13; I.G. Ex. 2 at 9 - 10; I.G. Ex. 3 at 8 - 10. Also for the reasons explained by Pat White, she placed Respondent's name on the transfer forms as the physician who had requested the transfer of both patients. Id. In the transfer forms completed for Delmar Mills and Sean Crum, Pat White had

placed Respondent's name as the physician who was certifying these two patients for transfer. I.G. Ex. 2 at 9 - 10; I.G. Ex. 3 at 8 - 10. In these transfer forms, both patients were designated as "unstable" at the time of transfer with the use of Respondent's name. Id.[14] Designating these patients as "unstable" at the time of transfer is consistent with the reasons recalled by Pat White for Dr. Hani's refusal to transfer these patients. I.G. Ex. 4 at 3.

Without dispute, there is no physician's signature appearing on the transfer forms for Sean Crum or Delmar Mills. The statute has placed an obligation on the physician to perform the specified evaluation, and then to sign or countersign the certification. See section 1867(c)(1)(A)(ii), (iii).[15]

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[14] Part 1, subpart 5, of Delmar Mill's transfer form was filled out in such as way that it conveys conflicting assessments of the patient's stability at the time of transfer. I.G. Ex. 2 at 9. The instructions for subpart 5 called for completing either "A" (certification that the patient's medical condition was stable at the time of transfer) or "B" (certification that the patient suffered from an emergency medical condition, but the medical benefits reasonably expected from the transfer outweigh the risks of transfer). However, both "A" and "B" were completed by Pat White, in Respondent's name. I.G. Ex. 2 at 9. However, notwithstanding the seemingly conflicting information certified in "A" and "B" of Part 1, subpart 5, the following page of the transfer form shows that Delmar Mills was denoted as "unstable" for his transfer. I.G. Ex. 2 at 10.

In the transfer form completed for Sean Crum, the information certified in Part 1, subpart 5, as well as on page 10 under "Informed Consent," shows that this patient was assessed as unstable at the time of transfer. I.G. Ex. 3 at 8 - 10. The certification of Sean Crum's unstable medical condition was done with use of Respondent's name. Id.

[15] Under two of the three alternatives permitted by section 1867(c)(1)(A), a physician must sign (or countersign, if the physician is not physically present in the emergency room at the time of the transfer) a certification that, based upon the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risk to the patient. Section 1867(c)(1)(A)(ii) and (iii) of the Act.

I will defer a discussion of my conclusion that the remaining alternative permitted by section 1867(c)(1)(A) was also not satisfied, due to the failure of Respondent and ARH to inform

(continued...)

Therefore, the testimony of Pat White, R.N., concerning how she made decisions about the patients' stability or instability, and how she assessed the risks and benefits of these patients' transfers, fails to establish compliance with the requirements of either section 1867(c)(1)(A)(ii) or (iii).

As discussed previously, I find it credible that Respondent told Pat White to effectuate the transfers of Sean Crum and Delmar Mills, that his instructions to Pat White included having her fill out the necessary transfer forms on his behalf (including placing his name on the forms), that Dr. Hani refused to order the transfer of these patients, and that Pat White asked Respondent to sign the transfer forms. I note also that Respondent's contention was that the patients should be transferred due to their need for surgery. Under these circumstances, Respondent was the only physician at ARH who could have, and should have, signed the certifications required by statute.

In addition to the absence of any physician's certification for the transfers, the evidence shows also that Sean Crum and Delmar Mills were transferred to St. Mary's Hospital because Respondent caused those in ARH's emergency room to believe that St. Mary's Hospital's on-call surgeon, Dr. Arya, had agreed to accept the transfers during his telephone conversation with Respondent. See I.G. Ex. 2 at 9 - 10; I.G. Ex. 3 at 8 - 10. It was not until Sean Crum and Delmar Mills were en route to St. Mary's Hospital and Pat White called to give St. Mary's a report on the patients' status that ARH was told by St. Mary's Hospital that these patients had not been accepted for transfer. Tr. 526. The physicians at St. Mary's Hospital voiced their outrage that ARH was treating its patients this way, and those physicians accused ARH's doctors of having deliberately violated federal laws. I.G. Ex. 4 at 4. A physician at St. Mary's Hospital even instructed the nurses at ARH's emergency room to turn back the ambulances transporting the two patients. Tr. 569 - 70. However, ARH's emergency room was unable to communicate with the ambulance and, therefore, both Sean Crum and Delmar Mills were transported to St. Mary's Hospital. Tr. 570; I.G. Ex. 2 at 13 - 14; I.G. Ex. 3 at 22.

The evidence establishes that there was, in fact, no agreement by St. Mary's Hospital to accept the transfer of either Sean Crum or Delmar Mills. Dr. Hani stated that he had never obtained St. Mary's acceptance for the transfers. I.G. Ex. 12. No physician had signed the two patients' transfer forms to certify that the receiving facility had

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[15](...continued)
those legally responsible for Sean Crum and Delmar Mills of the full extent of ARH's responsibilities to them.

available space and qualified personnel for providing the necessary care, or that the receiving facility had agreed to accept the transfers. I.G. Ex. 2 at 9 - 10; I.G. Ex. 3 at 9 - 10. Dr. Arya, of St. Mary's Hospital, stated that he never agreed to accept either of the patients for transfer when Respondent spoke to him by phone concerning Sean Crum's condition. I.G. Ex. 10; Tr. 300 - 04. Dr. Arya's testimony is corroborated by the note Respondent made in Sean Crum's record at 5 AM on September 15, 1991, which stated, "Dr. Arya in Huntington -- wants the surgery done here." I. G. Ex. 3 at 4.

After having used his questioning of witnesses to raise the possibility that Dr. Arya might have agreed to accept the transfers (see, e.g., cross-examination of Dr. Arya), Respondent admitted during the hearing that there was no authorization received from St. Mary's Hospital for the transfer of these two patients. Tr. 914. However, Respondent attempted to extricate himself from the consequences of his actions by noting repeatedly that he had written various words of "advice" to Dr. Hani in the patients' charts. In Sean Crum's medical records, Respondent wrote also:

> I advised Dr. Hani ER doctor to get proper authorization and to transfer this patient to Huntington/Charleston immediately . . . . The ER doctor arranges the transport at this facility. He feels he wants to wait for Helicopter. But I advised him to arrange transfer after obtaining the permission of the accepting party and to take whatever transport available immediately, as soon as possible.

I.G. Ex. 3 at 4. Respondent wrote these following notes in Delmar Mills' records as well:

> E.R. Doctor Hani is advised to transfer this patient after getting proper authorization from receiving facility. Take whatever transportation available - now. [I.G. Ex. 2 at 4.]
>
> I advised the E.R. Doctor again to get proper authorization prior to transfer to Bigger Facility Huntington/Charles and facilitate immediate transfer. Dr. Hani feels he wants to wait for helicopter to transfer. But I advised to take the transport that is available now. Not to waste any more time. [I.G. Ex. 2 at 6.]
>
> E.R. Doctor advised to transfer this patient after getting proper authorization from the receiving facility. [I.G. Ex. 2 at 8.]

Notwithstanding the contents of these notes Respondent wrote, there is no evidence to suggest that the nurses working in ARH's emergency room that morning, Pat White and Judy Hatfield, were informed by anyone that Respondent had failed to obtain acceptance of the two patients' transfer to St. Mary's Hospital. As discussed above, the evidence shows that everything they heard from Respondent following his phone call to Dr. Arya led them to believe that Respondent had obtained acceptance for the transfers, and that Respondent was the physician ordering these patients' transfers. Even the directive Respondent testified to having uttered immediately after his phone conversation with Dr. Arya, "Prepare for transfer," could not have reasonably have led those who heard it to suspect that St. Mary's might not have accepted these two patients' transfer during the phone call.

Even though Respondent placed the above quoted notes in the patients' files, Respondent does not allege that he conveyed the substance of those notes to Pat White, who prepared the transfer papers and obtained the use of ambulances under the belief that Respondent was directing her to do so. Nor does Respondent dispute the fact, apparent from these notes (i.e., despite having repeatedly written the word "advice,") that Respondent himself made the determination as the on-call surgeon that, as of 4:00 AM, these two patients should be transferred immediately from ARH. I re-emphasize here my earlier discussion and conclusion that it was Respondent, as the on-call surgeon, who had the duty and the prerogative to make the transfer decision, since the patients needed surgery and the alleged reason for transferring them was to meet their surgical needs.

Moreover, there is no evidence to show that Dr. Hani, to whom Respondent's written "advice" was addressed, was made aware before the two patients were taken away from ARH that Respondent had written such "advice" in the patients' charts. Dr. Hani stated in his Declaration[16] that he had refused Respondent's request to sign the "Emergency Services Transfer Records" for Sean Crum and Delmar Mills. I.G. Ex. 12. Dr. Hani explained that his medical judgment was that it would be medically inappropriate to transfer these patients by ground ambulance to St. Mary's Hospital, given their unstable medical condition. Id. Dr. Hani stated also that he had no

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[16] At Respondent's request, I issued a subpoena for Dr. Hani to testify at a supplemental hearing. Respondent did not avail himself of the opportunity to cross-examine Dr. Hani by use of the subpoena.

personal knowledge of whether Respondent had secured the acceptance of those patients from St. Mary's Hospital. Id.[17]

I view the "advice" Respondent wrote as self-serving and without any legitimate purpose. To consider Respondent's written statements as true "advice" to Dr. Hani, I would first have to overlook the very considerable body of evidence discussed above showing that, beginning at 4:00 AM, Respondent had, in fact, made the transfer decisions and begun to effectuate them through his directives to Pat White. Even if I could resolve these inconsistencies and draw a conclusion in Respondent's favor (which I have not done), it is obvious that Respondent's writing such "advice" in the charts was intended only to exculpate himself from the consequences of the actions he had already taken.

In concluding that Respondent's "advice" was not written with the intent to help bring the transfers of Sean Crum and Delmar Mills within the requirements of the law, I note first that Dr. Hani did not believe there to be any legitimate reasons for transferring these patients. Respondent could not have expected Dr. Hani to succeed in securing acceptance for the transfers when Respondent was aware that Dr. Hani objected to the transfers, had refused to sign the transfer papers as requested by Respondent, and knew nothing of the earlier phone conversation Respondent had held with Dr. Arya to discuss the transfers. See I.G. Ex. 12. Since the transfers were being made as a follow-up to Respondent's conversation with Dr. Arya,[18] then Respondent could not have

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[17] Dr. Hani's Declaration shows that, shortly after Sean Crum and Delmar Mills were admitted to ARH's emergency room, Dr. Hani did make a telephone call to the emergency room physician at St. Mary's Hospital, but no acceptance was obtained. I.G. Ex. 12. Unlike Respondent, Dr. Hani did not tell the nurses to prepare the patients for transfer after the St. Mary's emergency room physician refused to accept the two patients.

Given the chronological order of Dr. Hani's narration of events, it appears that Dr. Hani's call to the St. Mary's Hospital emergency room physician occurred prior to Respondent's call to Dr. Arya. Apparently, the result of Dr. Hani's call was known to Respondent, or Respondent would not have then called Dr. Arya and later written his advice for Dr. Hani to obtain acceptance for the transfers.

[18] According to Dr. Arya, Respondent discussed only the need to transfer Sean Crum. I.G. Ex. 10. Dr. Arya said that he was told by Respondent that the anesthesiologist at ARH was unwilling to anesthetize Sean Crum for surgery. Id. Dr.

(continued...)

expected Dr. Hani to succeed in securing proper authorization for the transfers, since Dr. Hani was not a party to the phone call between Respondent and Dr. Arya. Therefore, if there were any arguably legitimate reasons for transferring Sean Crum and Delmar Mills, those reasons were known only to Respondent, and could have been expressed only by Respondent.

Under the foregoing circumstances, Respondent cannot relieve himself of responsibility for having caused the transfers at issue by writing some self-serving statements in the patients' records -- especially when there is no evidence that he had told anyone of their contents when there was still time to abort the transfers he was causing to occur.

Section IV

In this section, I explain my reasons for having found and concluded as follows:

> **23. During the period between 4:00 AM and the time Sean Crum and Delmar Mills were transported away from ARH (at approximately 7:30 and 8:00 AM, respectively), these two patients' medical conditions were repeatedly described as "unstable" by Respondent, Dr. Hani, and the nurses who evaluated these two patients.**
>
> **24. Prior to transferring Sean Crum and Delmar Mills from ARH at approximately 7:30 AM and 8:00 AM, respectively, neither Respondent nor any other health care professional in ARH's emergency room had made a determination that either of these two patients' medical conditions had become stabilized, within the meaning of section 1867(e)(3)(B).**

The ambulance log shows that ARH requested transport for the transfer of Sean Crum and Delmar Mills at 5:15 AM, that the ambulances arrived at ARH at 5:30 AM, and that Sean Crum and Delmar Mills were taken away from ARH at 7:30 AM and 8:00 AM, respectively. I.G. Ex. 3 at 20.

Inasmuch as section 1867(c) of the Act applies only to the transfer of an individual with an emergency medical condition that has not been stabilized within the meaning of the Act, Respondent has introduced expert testimony that Sean Crum and Delmar Mills had, in fact, become stable at the time of their actual transfers from ARH. E.g., Tr. 356 - 60, 367 - 69

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[18](...continued)
Arya said he told Respondent to contact the Administrator of ARH to order the anesthesiologist to provide anesthesia services. Id.

(testimony of Dr. Hossein Sakhai)[19]; Tr. 437 - 38 (testimony of Dr. William Aaron); Tr. 606 - 7, 685 (testimony of Dr. Paul Fowler). These experts, who were called by Respondent to testify on this issue, never examined or treated Sean Crum or Delmar Mills. They did not have the opportunity to observe these two patients' conditions on September 15, 1991. They derived their opinions solely from a review of the medical records from ARH and St. Mary's Hospital. (Of course, the St. Mary's Hospital's records were not yet generated while the patients were at ARH.) The experts called by Respondent based their conclusions of "stability" primarily on the fact that the two patients not only were being kept alive with the resuscitative efforts given them in ARH's emergency room (e.g., the insertion of chest tubes and the transfusion of blood), but their blood pressure readings of record were also showing improvements. Id. The improvements in the blood pressure readings indicated that the rate of bleeding in the abdominal cavity was not very

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[19] Dr. Sakhai was the first health care professional to provide the opinion that the medical conditions of Sean Crum and Delmar Mills were stable at the time of their transfer. After Dr. Sakhai so testified, Pat White and Respondent also expressed the same or similar opinions during the hearing. Pat White, for example, attempted to explain that when she used the word "unstable" in the two patients' transfer forms, she really meant that the patients' conditions were guarded, but that they were fit for transfer. Tr. 507; see Tr. 523 - 24, 549 - 50. She also denied that Respondent had told her to designate "unstable" on the forms. Tr. 507. Respondent testified that he thought stabilization had occurred by 5:00 AM for Delmar Mills (Tr. 884), even though he had written at 4:00 AM that the patients should be transferred.

Given the inconsistencies inherent in the foregoing evidence, as well as other evidence discussed herein, I do not believe that on the morning of September 15, 1991, either Pat White or Respondent had formulated any belief, while they were evaluating or caring for Sean Crum and Delmar Mills, that either patient had become "stabilized" within the meaning of the law. Rather, much after the fact, Pat White and Respondent adopted the "stabilized" opinion expressed by Dr. Sakhai and other experts retained by Respondent for litigation. Both Pat White and Respondent had an incentive to adopt the "stabilized" opinion after the fact since, without these two individuals (one giving the directives to transfer, and the other following them and filling out the necessary forms) the transfers at issue would not have occurred as they did.

serious, or that the patients' blood loss was being adequately replaced at ARH.[20] Id.

I recognize from the foregoing testimony that, when more complete medical information is evaluated after the fact with the benefit of 20/20 hindsight, some experts can conclude that the emergency medical conditions of Sean Crum and Delmar Mills had become stabilized within the meaning of section 1867(e)(3)(B) of the Act at the time they were taken away from ARH at 7:30 AM and 8:00 AM, respectively.[21] However, for purposes of deciding Respondent's liability under section 1867 of the Act, I do not find it appropriate to use the opinions given after the fact and with use of information not available at the time of the alleged violations. My reasons are based on my interpretation of section 1867's intent (see Section V, below). I note by way of background here that the statute has placed the duty on those at the transferring institution to make certain determinations based on the facts available to them at the time of a transfer decision. See, e.g., section 1867(c)(1)(A)(ii) and (iii) of the Act. If the

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[20] The medical experts acknowledged that the blood pressure readings introduced into the record do not cover the entire time that both patients were in ARH's emergency room. E.g., Tr. 359. In the case of Delmar Mills, there are blood pressure readings done at 15 minute intervals by ARH entered on the document called "Nursing Care Record" from 3:12 AM until only 6:00 AM. I.G. Ex. 2 at 11. There is no similar document containing the blood pressure readings of Sean Crum done at regular intervals. See I.G. Ex. 3.

Judy Hatfield, R.N., testified as to her belief that the records from ARH concerning Sean Crum and Delmar Mills (I.G. Ex. 2 and 3) do not appear to be complete. Tr. 556 - 57.

[21] There is no consensus of after-the-fact expert medical opinion on this issue. For example, the I.G. pointed out in her post-hearing brief that the experts she called to testify, Dr. Michael Hannigan and Dr. William Browning, were of the opinion that stabilization had not been achieved within the meaning of the Act prior to the transfers at issue. I note, in addition, that Dr. Arya's reason for not having agreed to the transfer of Sean Crum (he said Respondent discussed only Sean Crum with him) was his belief that the patient should be stable. I.G. Ex. 1 at 6; I.G. Ex. 10. Thus, it appears that Dr. Arya also disagreed with the opinion that Sean Crum's medical condition had been stabilized prior to transfer. In addition, none of the physician witnesses testified that finding the patients unstable within the meaning of the statute prior to transfer would be a medically impermissible opinion.

determination made by the transferring institution pursuant to statute is that a patient's condition is unstable, then the statute dictates the actions which must be taken, without regard to whether other experts might later disagree with the unstable determination. Section 1867(c) of the Act. Therefore, for purposes of deciding the liability issue, I consider it material and of great significance that all the evidence of record points to the conclusion that, during the relevant hours on September 15, 1991, the health care professionals who actually evaluated or cared for Sean Crum and Delmar Mills at ARH's emergency room made explicit or implicit findings that their medical conditions were unstable -- and that the transfers were effectuated notwithstanding those health care professionals' belief that the two patients' medical conditions were unstable. There is no credible evidence showing that any doctor involved in the examination or treatment of these two patients at ARH had, in fact, made a "stabilized" determination from the time Respondent decided, at 4:00 AM, that the two patients should be transferred, until the two patients were actually taken away from ARH.

For example, as discussed earlier, Respondent said he thought abdominal surgery was appropriate for both patients, at 4:00 AM, because their conditions were unstable (see Tr. 849, 853, 894), even though he began also to write at 4:00 AM that both patients should be transferred (I.G. Ex. 2 at 17; Ex. 3 at 2). Dr. Arya testified that the information he received from Respondent indicated that "the patient as described . . . may not make it to us . . . ." Tr. 314. If Respondent had described any of the two patients as having been stable or stabilized during his telephone conversation with Dr. Arya, Dr. Arya would not have refused to accept the transfer based on his belief that a patient should be stable. See I.G. Ex. 1 at 6.

In addition, if Respondent had really thought either patient had became stabilized by 4:00 or 5:00 AM, as he alleged during the hearing (Tr. 878, 884), he would not have given Pat White instructions on the preparation of the forms necessary to transfer unstable patients in accordance with the Act. (She filled out one transfer form at 5:00 AM, and another one at 6:00 AM, pursuant to his instructions. I.G. Ex. 2 at 9; I.G. Ex. 3 at 8 - 9; e.g., Tr. 505.) Even at 5:30 AM, when the ambulances arrived to transfer the two patients (I.G. Ex. 2 at 12), Respondent wrote "I am willing to do surgery here for Laparotomy." I.G. Ex. 2 at 6. The final entries made by Respondent in the two patients' charts were to the effect that Dr. Hani should secure proper authorization for the transfers. E.g., I.G. Ex. 2 at 6, 8; I.G. Ex. 3 at 4. In fact, Respondent confirmed on cross-examination that it was his judgment that, for the entire time the two patients were at ARH (from the time they arrived

until they left), abdominal surgery was necessary, appropriate, and should have been done as soon as possible. Tr. 894.

If, as he now alleges, Respondent had thought the two patients had become stable while they were at ARH,[22] there would have been no need for him to write repeatedly in the patients' charts that Dr. Hani should secure "proper authorization" for the transfers. Nor would there have been a need for Respondent to continue to re-emphasize at the hearing the notes he allegedly wrote as advice to Dr. Hani for the effectuation of a lawful transfer applicable to patients who have not been stabilized. E.g., Tr. 878. Respondent wrote nothing in these two patients' medical records to show that, on the morning of September 15, 1991, he thought either patient had become stabilized at any time while they were at ARH.

The additional evidence noted elsewhere in this decision (e.g., Respondent's call to Dr. Arya, Respondent's statements and instructions to the nurses and Dr. Hani, Dr. Hani's objections to transfer, Pat White's preparation of the transfer forms, and the contents of the transfer forms) leads also to the conclusion that Respondent, along with everyone else caring for the two patients in ARH's emergency room, thought these patients' condition was unstable throughout their time at ARH. Moreover, if Pat White had not contacted St. Mary's Hospital when the ambulances were en route with information that indicated the two patients' unstable condition, the physicians at St. Mary's Hospital would not have reacted so vehemently or accused ARH of having violated federal laws.[23] In Pat White's account of the disagreement between Respondent and Dr. Hani concerning whether the

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[22] I do not find credible the suggestion that Respondent might have changed his opinion at the last minute about the two patients' stability. Respondent testified that he was not in the emergency room when Sean Crum and Delmar Mills were taken away from ARH. Tr. 877. He said he did not even known at what time the transfers occurred. Id. Therefore, he had no basis for changing his opinion about the patients' stability immediately prior to the transfers.

[23] The individual who conducted an investigation on behalf of the federal government reported that Dr. Arya's failure to accept Sean Crum's transfer was due to the principle that a patient should be stable. I.G. Ex. 1 at 6. (Dr. Arya said that Respondent had discussed with him only the possible transfer of Sean Crum. I.G. Ex. 10.) This is additional evidence that Respondent never formed a belief on September 15, 1991, that Sean Crum had become stabilized.

patients should be transferred, Respondent was not heard to have insisted on the transfers because he thought the patients were stable.

The evidence shows that, in Sean Crum's chart especially, Dr. Hani repeatedly used the word "unstable" to describe the patient, in addition to having written "Dr. Cherukuri aware of . . . unstable BP [blood pressure] -- wants to transfer pt. . . . . Condition critical." I.G. Ex. 3 at 14. Aside from the notations of "unstable" contained in the two transfer forms discussed above, there is also Dr. Hani's notation at the time the two patients were discharged from ARH's emergency room for transfer, that their conditions were "critical." I.G. Ex. 2 at 2; I.G. Ex. 3 at 18.[24] The foregoing evidence contemporaneously generated by Dr. Hani is consistent with his subsequent Declaration, which states that he was opposed to the transfers, that he had refused to sign the transfer forms, and that he believed it medically inappropriate to transfer either patient by ground ambulance, given their unstable medical condition related to internal bleeding. I.G. Ex. 12.

I think it significant also that, to date, no physician has signed or countersigned ARH's transfer forms for Sean Crum or Delmar Mills. As is obvious from their contents, these forms need to be used in order to ensure (through a physician's certification) that patients who are not stable within the meaning of the Act do not undergo transfers which violate the requirements of section 1867(c). See Tr. 229 - 30. No physician signed them to certify that the elements of the statute have been satisfied. Dr. Hani's refusal to sign these forms is understandable, since he had opposed the transfers due to his view that the patients' medical conditions were unstable. I.G. Ex. 4 at 3; I.G. Ex. 12.

However, whether or not Respondent was too busy to read or sign the transfer forms at the time Pat White completed the forms at Respondent's request, Respondent had the opportunity to read them or sign them later, because the originals of the forms stayed with the patients' charts. Tr. 534. Yet only his name (without his signature) appears on those forms. In addition, if the transfer forms contained information concerning the patients' stability which he thought was inaccurate or misleading, Respondent certainly had the opportunity to correct them before he appeared in person at a hearing almost five years later. Id.

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[24] Dr. Hani wrote the assessment of "critical" at 7:40 AM, September 15, 1991, for Sean Crum. I.G. Ex. 3 at 18. He did not write down the date and time for the same assessment in Delmar Mills' records. See I.G. Ex. 2 at 2. However, there is no basis for concluding that Dr. Hani did not write this information for both patients at about the same time.

If Pat White thought the patients' conditions had become stable, she had the same opportunity as Respondent to correct any misinformation she might have placed into the emergency transfer forms. Both Respondent and Pat White had an incentive to correct anything they perceived to be misstatements or inaccuracies on those transfer forms at a much earlier time, since their names appear on the forms. Yet, like Respondent, she did not begin to contradict or "explain" her written words until almost five years later, when she testified at the same hearing as Respondent. See, e.g., Tr. 529 - 31. Even when she prepared the incident report for ARH, shortly after St. Mary's Hospital called to complain of a "dumping violation," Pat White never mentioned that she or Respondent had believed that the patients were stabilized at the time of the transfers. I.G. Ex. 4. Even when an investigation was conducted on behalf of the federal government in January of 1992, pursuant to charges that section 1867 of the Act had been violated, neither Respondent nor Pat White told the investigators that they thought Sean Crum or Delmar Mills had been stabilized by the time each was taken from ARH. I.G. Ex. 1; Tr. 213.

In sum, I have found no credible evidence establishing that, prior to the time Sean Crum and Delmar Mills were taken from ARH, Respondent or anyone else who evaluated or cared for these patients at ARH's emergency room had ever changed their opinion about the two patients' having unstable emergency medical conditions. These health care professionals' words and deeds throughout the time that the two patients were at ARH's emergency room indicate that they thought the patients were to be transferred to St. Mary's Hospital with an unstable medical condition. Therefore, I find no adequate basis for believing that, prior to the transfers on September 15, 1991, Respondent or other health care professionals at ARH's emergency room had changed their opinion that Sean Crum and Delmar Mills' emergency medical condition remained unstable throughout the time they were at ARH.

Section V

In this section, I discuss my reasons for having found and concluded as follows:

> **25. The intent of section 1867 of the Act is to have the doctors actually involved with the evaluation or treatment of patients at a participating hospital's emergency room protect their patients' health and safety by following (or causing to be followed) the statutory requirements of subsection (c), whenever and for so long as they determine that the patients' medical condition is "unstable."**

26. A physician's duties under section 1867(c) of the Act follow automatically from any determination that a patient is "unstable," made pursuant to a request for emergency medical treatment, without regard for whether other experts reviewing the same or additional information after the fact would disagree with the "unstable" determination.

27. Section 1867(c) of the Act's prohibitions against transfers until patients have been stabilized, became applicable to Sean Crum and Delmar Mills pursuant to the determinations of "unstable" made by Respondent and other health care professionals in ARH's emergency room.

28. Section 1867(c) of the Act's prohibitions against transfers until patients have been stabilized remained applicable to Sean Crum and Delmar Mills throughout the time they were at ARH.

I find untenable the legal theory implicitly advanced by Respondent to avert liability: that even though on the morning of September 15, 1991, Respondent and Dr. Hani had determined that the patients' medical conditions were unstable while they were in ARH's emergency room, Respondent and others at ARH were not required to proceed in accordance with section 1867(c) of the Act on that day because, several years after the event, experts retained by Respondent for litigation concluded from their review of medical documents that the patients had become stabilized prior to or at the time of their transfer. Section 1867 of the Act has placed the duty to make determinations of "stability" on a participating hospital with an emergency room (including the doctors who are affiliated directly or indirectly with the hospital) -- not on those experts retained to provide their expert opinions after the fact. Where, as in this case, "unstable" was the only determination explicitly and implicitly made while the patients were in ARH's emergency room, the statute required the taking of all actions consistent with the "unstable" determination.

In an emergency situation, it is especially necessary and appropriate for a hospital and its physicians to take actions consistent with their evaluation of a patient's medical condition. This means that if a patient is determined to be unstable in the emergency room, the requirements of section 1867(c) must be followed without regard for whether other professionals who did not evaluate or care for the same emergency medical condition might agree at a later time that a patient was stable. The health and safety of patients in emergency rooms cannot be adequately protected unless the obligations and liabilities specified by section 1867(c) of the Act become applicable at the moment an "unstable"

determination is made by the doctor(s) charged with the actual evaluation or treatment of those patients.

The intended beneficiaries of the statute are those individuals who seek help at participating hospitals' emergency rooms. For the safety and protection of these individuals, such hospitals and their affiliated doctors cannot be permitted to effectuate transfers in disregard of the "unstable" determinations they make. Requiring adherence to the requirements of section 1867(c) will cause no harm to the intended beneficiaries of the Act even if the "unstable" determination made at the time of their examination becomes subject to disagreement after the fact. In contrast, the health and safety of patients in emergency rooms can be placed at risk if those professionals examining the patients conclude that their medical condition is "unstable," but they then fail to take all of the actions required by section 1867(c) of the Act for the protection of those patients' health.

The facts of this case underscore the reasons why a participating hospital, and the doctors working in its emergency room, must take action consistent with the "unstable" determinations they make. The evidence discussed above leaves no doubt that, as of 4:00 AM on September 15, 1991, Sean Crum and Delmar Mills did not have stable medical conditions.[25] Resuscitative efforts had barely begun at that point, and there was not yet any improvement in their blood pressure readings. E.g., I.G. Ex. 2 at 11. If these patients had been transferred at 4:00 AM, when Respondent first indicated that the transfers should take place, the patients' lives might have been jeopardized. However, the weather conditions were poor that morning and prevented the use of helicopter transport. E.g., Tr. 495 - 96, 982; I.G. Ex. 3 at 18. Pat White testified that the ambulance service was called pursuant to Respondent's directions only because the helicopter could not fly that morning. Tr. 496. If the weather had permitted the use of helicopter transport, it seems extremely unlikely that the two patients would have had the opportunity to remain in ARH's emergency room for several hours and improve with the continued transfusion of blood and fluids. Therefore, weather conditions prevented the

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[25] Some parts of Dr. Fowler's testimony suggest that Sean Crum may have been stable at about 4:00 AM. E.g., Tr. 675 - 83. However, I have not accepted this possible conclusion, since Dr. Fowler consistently failed to articulate a reasonable, factual basis for this opinion during cross-examination. Id. He testified also that he did not know precisely when stabilization began (Tr. 679), but that Mr. Crum was unstable, in his opinion, when Mr. Crum arrived at ARH (Tr. 683), and prior to the insertion of a chest tube at an undeterminable times (Tr. 679).

transfers at or near 4:00 AM, even though section 1867 of the Act placed the responsibility for safeguarding patients' health and safety with the hospital and its doctors.

For the protection of the individuals seeking treatment at a participating hospital's emergency room, I deem the duties under section 1867(c) of the Act to follow automatically from a determination of "unstable" made pursuant to a request for emergency medical treatment, without regard to whether other experts reviewing the same information after the fact would agree or disagree with the "unstable" determination. Under the facts of this case, I conclude that the obligations specified by section 1867(c) of the Act were triggered as soon as Respondent and Dr. Hani made the determination that Sean Crum and Delmar Mills each had an emergency medical condition that was unstable. See sections 1867(b), (c), (e)(1), and (e)(3)(A) of the Act. The duties under section 1867(c) of the Act remained applicable because the determination of "unstable" was never changed to "stable" or "stabilized" by those physicians responsible for evaluating these patients at ARH.

Section VI

In this section, I discuss my reasons for having reached the following findings and conclusions:

> **29. Without the agreement of St. Mary's Hospital to accept the transfers, the transfers of Sean Crum and Delmar Mills were not the "appropriate transfers" required by section 1867(c)(1)(B) of the Act.**
>
> **30. The transfers of Sean Crum and Delmar Mills were made in violation of section 1867(c)(1), which requires an "appropriate transfer" under subparagraph (B), without regard to whether any of the additional requirements of section 1867(c)(1)(A) have been satisfied.**
>
> **31. It is immaterial whether St. Mary's Hospital was a tertiary care facility or had the capacity to treat the emergency medical conditions of Sean Crum or Delmar Mills without advance notice.**

I conclude that violations under section 1867(c) of the Act have been established by the very fact that Sean Crum and Delmar Mills were transferred without acceptance from St. Mary's Hospital after they had been determined by Respondent and Dr. Hani to be unstable. In addition to the various alternative requirements specified in subpart (A) of section

1867(c)(1),[26] subpart (B) mandates that the transfer must also satisfy the definition of "an appropriate transfer." Section 1867(c)(1)(B). As a matter of law, a transfer is not "an appropriate transfer" if the receiving facility did not agree to accept transfer of the patient and to provide appropriate medical treatment. Section 1867(c)(2)(B)(ii).

I conclude that a violation of section 1867(c) has occurred with respect to each of the two transfers discussed above, even though Respondent has introduced evidence to show that St. Mary's Hospital, as a designated trauma center, was without any valid reason for refusing any transfer request because it should have been in a state of constant readiness to provide emergency care. E.g, Tr. 418 - 19. This line of evidence introduced by Respondent is immaterial.[27] The statute does not require the securing of acceptance from only those hospitals without trauma center designations. Being a trauma center does not mean that the facility will never run out of available space or qualified personnel for the care of additional patients. See section 1867(c)(2)(B)(i) of the Act. Moreover, the multiple notes Respondent wrote as "advice" to Dr. Hani show that Respondent was well aware of the requirement that the accepting facility's consent to the

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[26] Even though I have found that no physician has signed or countersigned the certification required by section 1867(c)(1)(A)(ii) and (iii) of the Act (**FFCL 19, 21**), I do not conclude at this juncture that a violation has occurred under section 1867(c) by virtue of said fact. Nor do I conclude at this juncture that a violation has occurred under section 1867(c)(1)(A) of the Act due to the absence of any certification signed or countersigned by a physician. The reason is that the signing or countersigning of certifications are merely two alternative requirements of section 1867(c)(1)(A).

I will defer until later my discussion of the evidence relevant to the third alternative requirement (that "the individual (or legally responsible person acting on the individual's behalf), after being informed of the hospital's obligations under this section and of the risks of transfer, in writing, requests transfer to another medical facility . . . ." section 1867(c)(1)(A)(i) of the Act), as well as my conclusion that the third alternative requirement of section 1867(c)(1)(A) has been violated also.

[27] It is also not true that a hospital designated as a trauma center cannot have a reasonable basis for refusing to accept a transfer. A participating hospital with specialized capability is only prohibited from refusing an "appropriate transfer." Section 1867(g) of the Act. In this case, the transfers were not "appropriate transfers" within the meaning of the law.

transfers must be received prior to the transfers. Respondent did not appear to have held the opinion, as suggested by some of his witnesses, that St. Mary's agreement to the transfers was not necessary.

Section VII

In this section, I discuss my reasons for having made the following findings and conclusions:

> **32. Respondent was responsible for examining Sean Crum and Delmar Mills while they were at ARH.**
>
> **33. Respondent was responsible for unlawfully transferring Sean Crum and Delmar Mills from ARH to St. Mary's Hospital.**
>
> **34. On the issue of Respondent's liability under section 1867(d) of the Act, it is immaterial whether Respondent should be classified as a consulting physician, attending physician, or any other type of physician.**
>
> **35. Respondent did, in fact, make the decision to transfer both Sean Crum and Delmar Mills.**
>
> **36. As the on-call surgeon, Respondent has liability under section 1867(d)(1)(B) for his actions which resulted in the transfers of Sean Crum and Delmar Mills in violation of section 1867(c) of the Act.**

For purposes of ascertaining Respondent's liability, the material issue is whether Respondent negligently violated a requirement under section 1867 of the Act -- not whether Respondent was the only person who violated said statute. Clearly, Respondent did not act alone during the morning of September 15, 1991. Neither Sean Crum nor Delmar Mills could have been transferred if, for example, Pat White had not effectuated Respondent's instructions by filling out the transfer forms with the use of Respondent's initials or had not called the transport service at his direction. However, the Act does not specify that only one individual may be held liable for negligent violation of the law. Nor does the statute relieve Respondent of liability if someone else may have been more responsible than he for having caused the transfers under consideration. Every responsible physician may be penalized for a violation of section 1867, even if there are other physicians who may be subject to a penalty for the same type of violation with respect to the same individuals. See 42 C.F.R. § 1003.102(d)(4).

As noted already, Respondent was summoned to ARH the morning of September 15, 1991, to examine Sean Crum and Delmar Mills. His responsibility for examining these patients is not in doubt. Section 1867(d)(1)(B) of the Act makes a physician liable for his negligent violation of the law if he was responsible for the examination, treatment, or transfer of a patient in a participating hospital. Said section of the Act specifically includes "a physician on-call for the care of such an individual . . . ." Section 1867(d)(1)(B) of the Act. Moreover, by its very definition, a "transfer" within the meaning of the statute can be effectuated by any individual with direct or indirect affiliation or association with ARH. Section 1867(e)(4) of the Act. Respondent, as the on-call surgeon, had such direct or indirect affiliation or association with ARH on September 15, 1991.

Therefore, in determining Respondent's liability for the events of September 15, 1991, I do not find it necessary to adjudicate the merits of Respondent's proof that he did not have the duties of an attending or treating doctor to Sean Crum and Delmar Mills. See, e.g., Tr. 602 - 4, 616 - 19, 1013T. Whatever title Respondent might have had in his relationship with Dr. Hani and the two patients, I have concluded already that Respondent's words and deeds caused Sean Crum and Delmar Mills to be transferred in contravention of section 1867(c) of the Act. It was Respondent who had, in fact, made the transfer decisions. Therefore, Respondent was responsible for the transfers of Sean Crum and Delmar Mills.

In addition to Dr. Michael Hannigan's testimony that a standard in the medical profession is for the surgeon to make the transfer decision if the service needed is surgery (Tr. 107), even the expert opinions Respondent presented contain support for the foregoing conclusions on Respondent's responsibility for the transfers. Dr. Aaron, one of the experts who testified for Respondent, said Respondent was a consulting specialist to ARH's emergency department and its doctor. Tr. 1013T. However, Dr. Aaron stated also that Respondent had the qualification to make a determination as to the patients' surgical stability and would be in a position to decide whether the benefits of transfer would outweigh its risks. Tr. 1036T. Dr. Aaron acknowledged that Respondent had "made the medical judgment" and "required the transfer" if (as the I.G. has successfully proven in this case) Respondent had told the staff that he had obtained acceptance of the transfers. Tr. 1037T. Another opinion Dr. Aaron formed after reviewing the relevant documents was that Respondent gave the order for transfer, though he did not co-sign his order. Tr. 469 - 70. Dr. Fowler, also an expert who testified for Respondent, pointed out that Respondent "stepped in when he didn't have to." Tr. 616. The gist of Dr. Fowler's opinion is that, even though Respondent did not have to intervene in the decision to transfer the two patients because Respondent never became their attending

physician, Respondent did intervene, nevertheless, to effectuate the patients' transfers over Dr. Hani's refusal to sign the necessary forms due to the patients' unstable medical condition. Tr. 617 - 19. As also noted earlier, the transfers were effectuated without the proper authorization from the receiving hospital.

The evidence introduced by the I.G. shows that Respondent is liable under section 1876(d)(1)(B) of the Act because: he was the on-call surgeon for ARH during the morning in question; he was affiliated or associated directly or indirectly with ARH by virtue of his status as the on-call surgeon; he was given the responsibility of examining Sean Crum and Delmar Mills when he was summoned in his capacity as the on-call surgeon; he assumed responsibility for the decision to transfer these two patients; these two patients were, in fact, moved to St. Mary's Hospital at the direction of Respondent; and the transfers were done without compliance with all the requirements of section 1867(c) of the Act. Section 1867(e)(4) and (d)(1)(B) of the Act.

Section VIII

In this section I discuss my reasons for having made the following findings and conclusions:

37. The Act relieves from liability only the physician who "orders the transfer" of a patient after he has made a determination that, without the services of an on-call physician, the benefits of transfer outweigh its risks. Section 1867(d)(1)(C) of the Act.

38. As a matter of law, the affirmative defense under section 1867(d)(1)(C) of the Act is not available to a physician in Respondent's situation who has not only denied having ever ordered either of the transfers at issue, but who has also never signed or counter-signed the transfer forms to certify that he was the physician who made the risk-benefit evaluation specified by law.

39. Respondent's affirmative argument that Dr. John Thambi, the on-call anesthesiologist, had refused to provide anesthesia to Sean Crum or Delmar Mills at ARH bears on the degree of Respondent's culpability, and the nature or circumstances of the violation under section 1867(c) of the Act.

40. The degree of Respondent's culpability, and the nature or circumstances of the statutory violation, are relevant to the issue of whether the amount of the civil monetary penalty assessed by the I.G. is reasonable.

41. In determining the degree of Respondent's culpability and the nature or circumstances of the statutory violation, it is appropriate to consider whether the following requirements of section 1867 have been violated also through Respondent's actions or omissions:

A. that "the transferring hospital provides the medical treatment within its capacity which minimizes the risks to the individual's health . . . ." (section 1867(c)(2)(A) of the Act);

B. that "the individual (or a legally responsible person acting on the individual's behalf) after being informed of the hospital's obligations under this section . . . in writing requests transfers to another medical facility . . . ." (section 1867(c)(1)(A)(i) of the Act).

The I.G. has established a prima facie case of Respondent's liability for the transfers of Sean Crum and Delmar Mills, which were made without the agreement of the receiving hospital and which, therefore, constituted violations of section 1867(c) of the Act. Accordingly, Respondent was entitled to prove any affirmative defenses which could materially affect the existence or extent of his liability.

Section 1867(d)(1)(C) of the Act relieves a physician of liability if he has authorized a transfer because an on-call physician fails or refuses to appear within a reasonable period of time after being notified to do so, and the physician ordering the transfer has determined that, without the services of the on-call physician, the benefits of transfer outweigh the risks of transfer.

Respondent has asserted as an affirmative defense that he advised the transfer of Sean Crum and Delmar Mills because he lacked the services of an anesthesiologist to assist him in performing the exploratory laparotomies he thought were necessary and appropriate to stabilize the emergency medical conditions of both patients. As noted above, Respondent had written at 3:45 AM (for Sean Crum) and at 4:00 AM (for Delmar Mills) his determination that this surgical procedure should be done. However, at 4:00 AM, he also made written determinations that each of these two patients should be

transferred immediately. At the time he was making the foregoing notes, Respondent wrote also the following for Delmar Mills:

> Anesthesiologist not willing to put the pt to sleep. He advised transfer immediately to Cable Huntington hospital.

(I.G. Ex. 2 at 17), and the following for Sean Crum:

> Dr. Thambi refused to give anesthesia.

(I.G. Ex. 3 at 2).

I conclude that, as a matter of law, the affirmative defense under section 1867(d)(1)(C) of the Act is not available to a physician in Respondent's situation. Respondent has not only denied having ever ordered either of the transfers at issue, but he has also never signed or counter-signed the transfer forms to certify that he made the risk-benefit evaluation specified by law. Very clearly, the statute relieves from liability only the physician who "orders the transfer" after he has made the determination that, without the services of the on-call physician, the benefits of transfer outweigh its risks. Section 1867(d)(1)(C) of the Act.

In this case, Respondent caused the transfers to occur under the circumstances discussed above.[28] For liability to attach under section 1867(d)(1)(B) of the Act, Respondent need only have been a physician "responsible for the examination, treatment, or transfer . . . ." He did not need to be the physician who ordered the transfer and made the risk-benefit determination for the transfer. Section 1867(d)(1)(B) of the Act. By contrast, the exception to liability created by section 1867(d)(1)(C) is available only to a physician who takes the responsibility for ordering a transfer after having made a determination regarding the risk of a transfer as opposed to the benefit of a transfer in the absence of a needed on-call physician.

In this case, Respondent has denied responsibility for the transfers at issue and has failed or refused the opportunity to sign the transfer certifications containing the risk-benefit analysis prepared for him by Pat White. Accordingly, Respondent cannot avail himself of the affirmative defense under section 1867(d)(1)(C) of the Act to escape liability.

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[28] It is not necessary that I decide in this case which doctor, if any, ordered the transfer of Sean Crum or Delmar Mills.

However, I will evaluate Respondent's allegations concerning the unavailability of an anesthesiologist's assistance, because the merits of such allegations have relevance to other issues in this case which bear on the reasonableness of the penalty imposed against Respondent.

I note first that, in addition to requiring the transferring hospital to secure the acceptance of the receiving facility, the definition of an "appropriate transfer" requires also that the transferring hospital "provides the medical treatment within its capacity which minimizes the risks to the individual's health . . . ." Section 1867(c)(2)(A) of the Act. Here, it is Respondent's contention that he wanted to do abdominal surgery on Sean Crum and Delmar Mills at ARH, even after having told the nurses to prepare for the patients' transfer, and that he would have done such surgery prior to their transfer had Dr. Thambi not refused to provide anesthesia.[29] Therefore, the issue of whether ARH (with Respondent as its on-call surgeon) provided medical treatment within its capacity to Sean Crum and Delmar Mills to minimize the risks to their health, as required by section 1867(c)(2)(A) of the Act, depends, in turn, on the merits of Respondent's contention that Dr. Thambi had refused or failed to provide anesthesia.

Even though I have found already that the absence of agreement by St. Mary's Hospital has rendered the transfers under consideration inappropriate under section 1867(c)(2)(B) of the Act, whether other sections of the Act have been violated due to Respondent's negligence bears on the issue of how much of the CMP imposed against him is reasonable. Under the regulations specifying those factors to be considered in setting the CMP amount, the I.G. was required to consider the degree of Respondent's culpability and the nature or circumstances of the violations. 42 C.F.R. § 1003.106(a)(4).

For the same reasons, I now consider the merits of the allegations concerning Dr. Thambi's unavailability as it bears on the issue of whether those legally responsible for Sean Crum and Delmar Mills gave their consent to transfer, after being informed of ARH's obligations under section 1867. See section 1867(c)(1)(A)(i) of the Act.[30] As indicated

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[29] I note, for example, that Respondent testified to having continued to search for an anesthetist for surgery after he advised Dr. Hani and the nurses, at 4:00 AM, to transfer the patients immediately. I.G. Ex. 2 at 17; I.G. Ex. 3 at 2; Tr. 857 - 59.

[30] I read the statutory requirements as meaning that the responsible individuals must have been truthfully informed of the hospital's obligations under section 1867 of the Act.

above, because Respondent had caused the transfers to be made in the absence of any agreement from St. Mary's Hospital, this fact alone was sufficient to establish Respondent's liability under section 1867 of the Act. To resolve the question of whether Respondent was liable for a negligent violation of section 1867(c), it was not necessary for me to analyze also whether, for example, the transfers were made after the two patients' families were told of ARH's obligations under section 1867. See section 1867(c)(1)(A)(i). However, what information the parents of Sean Crum and Delmar Mills were given by Respondent and others at ARH concerning ARH's obligations prior to transfer bears on the extent of the statutory violations and the nature or circumstances of the violations. The extent to which section 1867 of the Act has been violated, and how such violations occurred, are factors relevant to the issue of whether the CMP amount assessed by the I.G. is reasonable.

Section IX

In this section, I discuss my reasons for having found and concluded as follows:

> **42. I do not find credible Respondent's contention that Dr. Thambi failed or refused to appear at ARH's emergency room within a reasonable period of time after having been notified to do so.**
>
> **43. I do not find credible Respondent's contention that he directed or instructed Dr. Thambi to administer anesthesia to Sean Crum or Delmar Mills.**
>
> **44. I do not find credible Respondent's contention that Dr. Thambi refused to administer anesthesia to either Sean Crum or Delmar Mills.**
>
> **45. Since Respondent believed that surgery was appropriate, it was Respondent's duty (as the on-call surgeon) to direct Dr. Thambi to administer anesthesia and to eliminate any misunderstanding that may have existed as to whether Respondent wanted to proceed with surgery.**
>
> **46. Respondent failed to exercise his authority over Dr. Thambi to ensure that the necessary surgery could be performed on Sean Crum and Delmar Mills at ARH.**
>
> **47. I do not find that Respondent's culpability for the unlawful transfers of Sean Crum and Delmar Mills has been lessened by the evidence relevant to Respondent's assertion that Dr. Thambi's services were not available.**

48. The evidence relevant to Respondent's assertion that Dr. Thambi's services were not available establishes that Respondent had responsibility also in violating, with respect to the transfers of Sean Crum and Delmar Mills:

> A. section 1867(c)(2)(A)'s requirement that ARH provide "the medical treatment within its capacity which minimizes the risks to the individual's health . . . .";
>
> B. section 1867(c)(1)(A)(i)'s prohibition against transferring an individual unless "the individual (or a legally responsible person acting on the individual's behalf) after being informed of the hospital's obligations under this section . . . in writing requests transfer to another medical facility . . . ."

49. Respondent was in the best position to satisfy the requirements of section 1867(c)(2)(A) of the Act, by providing, on behalf of ARH, the medical treatment within its capacity, in order to minimize the health risks to Sean Crum and Delmar Mills prior to their transfers.

50. Respondent was in the best position to satisfy the requirements of section 1867(c)(1)(A)(i), by informing the families of Sean Crum and Delmar Mills that ARH's on-call surgeon had a duty to perform the necessary surgery at ARH and, if appropriate, to direct its on-call anesthesiologist to provide his services as well.

51. The evidence relevant to Respondent's assertion that Dr. Thambi's services were not available, together with other evidence discussed in sections III and VIII for FFCL 19, 21, and 38, regarding the failure of the physician to sign or counter-sign the certifications, above, establishes that Respondent had responsibility for transferring Sean Crum and Delmar Mills, in violation of section 1867(c) of the Act, when none of the exceptions specified in section 1867(c)(1)(A) were applicable.

52. The evidence relevant to Respondent's assertion that Dr. Thambi's services were not available, together with the evidence discussed in sections II, III, and VI, for FFCL 13, 19, 22, and 29 (regarding the absence of acceptance by St. Mary's Hospital), above, establishes that Respondent is responsible for having caused the transfers of Sean Crum and Delmar Smith in

violation of the "appropriate transfer" requirement of section 1867(c)(1)(B) on two grounds:

A. by failing to provide the medical treatment within ARH's capacity in order to minimize the health risks to Sean Crum and Delmar Mills (see, section 1867(c)(2)(A) of the Act); and

B. by failing to obtain St. Mary's Hospital's agreement to accept the two transfers (see, section 1867(c)(2)(B)(ii) of the Act).

In deciding the degree of Respondent's culpability, I begin by noting that there is no dispute among the medical experts that abdominal surgery could not have been performed on Sean Crum or Delmar Mills without the services of an anesthesiologist. E.g., Tr. 153. Nor is there any dispute that Dr. Thambi was contacted at his home by ARH in his capacity as the on-call anesthesiologist during the morning of September 15, 1991. I.G. Ex. 9. Dr. Thambi could have reached the hospital from his home in 15 minutes or less. Tr. 483, 876**T**. Dr. Thambi admitted that he did not go to the hospital until sometime after 6:40 AM and before 6:55 AM. Tr. 875**T**; I.G. Ex. 2 at 7. He admitted also that he was not in favor of administering anesthesia to patients such as Sean Crum and Delmar Mills, who had head injuries. E.g., I.G. Ex. 9. Additionally, there is no dispute that, if a surgeon decides that surgery should be performed, it is the surgeon's duty to tell the anesthesiologist to administer anesthesia, and it is the surgeon's responsibility to resolve any misunderstandings that may exist with the anesthesiologist. Tr. 980**T**, 1009**T**.

As detailed below, Respondent's position is that, not only did Dr. Thambi fail or refuse to come to the emergency room within a reasonable period of time after having been notified to do so repeatedly, Dr. Thambi had also outright refused to administer anesthesia to the two patients when Respondent spoke with him by phone and in person. Dr. Thambi's version of events, as will be discussed also below, is that prior to the telephone call he received at approximately 6:30 AM from Respondent, no one at ARH had asked him to come in to the emergency room after he had reminded them of ARH's longstanding policy of transferring all head injury cases to other hospitals. Dr. Thambi contends also that he was never asked to evaluate Sean Crum for anesthesia.

Having considered the conflicting version of events, I conclude that there is insufficient credible evidence to support Respondent's contention that Dr. Thambi failed to come to the emergency room when he was initially instructed to do so prior to the 6:30 AM phone call. I conclude also that there is insufficient credible evidence to support Respondent's contention that he had directed Dr. Thambi to

administer anesthesia to either Sean Crum or Delmar Mills. Accordingly, there is insufficient evidence to support Respondent's contention that Dr. Thambi refused to administer anesthesia.

I begin chronologically, with the first telephone call made from ARH's emergency room to Dr. Thambi. The evidence is relatively consistent in establishing that Dr. Thambi was first contacted by telephone between 4:00 AM to 4:30 AM during the morning in question. However, there are conflicts in the evidence concerning who actually spoke to Dr. Thambi by phone during this period of time and what was said.

According to Pat White, it was she who placed the first call to Dr. Thambi at Respondent's request, after Respondent had examined all five victims of the car accident who were in ARH's emergency room, and after Respondent had decided to perform surgery on Sean Crum and Delmar Mills. Tr. 480. Given Respondent's testimony that he did not decide to do surgery until about 4:00 AM (Tr. 849, 853), after having used the 15 minutes after his arrival at the emergency room to establish the diagnosis of internal injuries (Tr. 848), it is unlikely that Pat White placed the call to Dr. Thambi until at least 4:00 AM.

Dr. Thambi's testimony concerning the first telephone call he received during the morning in question is generally consistent with the account provided by Pat White, who testified also that she never specifically told Dr. Thambi to come to the hospital, but had said, instead, that Respondent needed him because some of patients involved in a car accident were critically injured. Tr. 481 - 83. At first, Dr. Thambi testified to having received a call at between 4:15 and 4:30 AM, but he could not remember who had made the call to him. Tr. 254. However, when recalled as a witness several weeks later, he testified that the initial call was made to him by a nurse (possibly Pat White) at sometime between 4:00 to 4:15 AM and that the nurse asked him to come into the hospital because two patients with abdominal as well as head injuries needed surgery. Tr. 874 -75T.[31] Dr. Thambi denied having spoken with Respondent at that time or having been told by Respondent of any decision to do surgery. Tr.

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[31] I believe that a professional standard of conduct noted by Dr. Aaron explains why, even though Pat White said she never expressly told Dr. Thambi to come to the emergency room, Dr. Thambi understood that he was being asked to do so. According to Dr. Aaron, doctors are guided by professional courtesies in these types of situations. Tr. 421. Therefore, Dr. Thambi knew when he was contacted as the on-call anesthesiologist that he was being asked to come and evaluate the patients in the emergency room, even though those exact words were not used by Pat White.

876T. Pat White's testimony at hearing did not indicate that she told Dr. Thambi during the first phone call that Respondent had decided to do surgery on any patient.

However, Respondent alleges to have spoken with Dr. Thambi by telephone at approximately 4:00 AM, and to have told Dr. Thambi at that time that the two patients needed abdominal surgery immediately, despite their head injuries. Tr. 849. According to Respondent's account of the facts, Dr. Thambi stated during the 4:00 AM telephone call with Respondent that he would not put the patients "to sleep" because they had head injuries. Id. Respondent testified that he told Dr. Thambi during this 4:00 AM phone call to come to the emergency room and that Dr. Thambi said he would do so. Id. Respondent alleged also by his testimony that he instructed Pat White to call Dr. Thambi again, after Dr. Thambi failed to arrive at the hospital within 15 minutes of the telephone call at 4:00 AM. Tr. 850. Respondent claims to have made three calls to Dr. Thambi. Tr. 854.

Pat White testified that she also called Dr. Thambi at least three times before Respondent "finally had to end up calling him." Tr. 484. Whether or not she did, in fact, make three additional calls to Dr. Thambi, Pat White's testimony indicates the elapse of some time between when she first called Dr. Thambi at approximately 4:00 AM, and when Respondent "finally" spoke to Dr. Thambi. Nothing said by Pat White at hearing indicated that there was any reason for Respondent to call Dr. Thambi immediately after she concluded her initial call to him. Therefore, the testimony provided by Pat White at hearing appears to be consistent with Dr. Thambi's contention that he never spoke with Respondent by telephone until approximately 6:40 AM. Tr. 874 - 76T.

However, even though Pat White's testimony appears to support Dr. Thambi's account of having not spoken to Respondent until approximately 6:40 AM, there is a part of the incident report Pat White prepared for ARH shortly after September 15, 1991, which lends support to Respondent's testimony that he spoke with Dr. Thambi at approximately 4:00 AM. Pat White stated in the incident report that, prior to Respondent's calling Dr. Arya of St. Mary's Hospital, Respondent had called Dr. Thambi for anesthesia, hung up the telephone, and then told everyone that the patient needed to be transferred because Dr. Thambi did not want to "put him to sleep." I.G. Ex. 4 at 3. Pat White's statement in the incident report is generally consistent with Respondent's notation in Sean Crum's chart that Dr. Thambi was "not willing to put the pt to sleep. He advised transfer immediately . . . ." I.G. Ex. 2 at 17.

Based on the foregoing material conflicts in the evidence concerning what, if any, conversation took place between Dr. Thambi and Respondent at or around 4:00 AM, I conclude that there is no preponderance of any credible evidence

establishing that Respondent spoke to Dr. Thambi at approximately 4:00 AM. Therefore, I do not find adequate support for Respondent's contention that Dr. Thambi refused to administer anesthesia when asked to do so at or around 4:00 AM.

Nor do I find sufficient credible evidence to support Respondent's contention that he and Pat White made several telephone calls to Dr. Thambi between approximately 4:00 AM and 6:30 AM, in order to seek his assistance at surgery (e.g., Tr. 484, 854). Respondent asserts this to show that, by failing to come to ARH's emergency room for approximately two and one half hours, Dr. Thambi was exhibiting his refusal to provide anesthesia to Delmar Mills and Sean Crum. I do not find such evidence credible, for essentially the same reasons as those (to be discussed below) which led me to disbelieve Pat White's testimony that, after Dr. Thambi arrived in the emergency room, she heard Dr. Thambi tell Respondent that he was refusing to give anesthesia to the two patients. See Tr. 487. I have not found sufficient evidentiary support for Respondent's contention that Dr. Thambi uttered any outright refusal to administer anesthesia during the morning in question.

What I find believable is that, on the morning of September 15, 1991, Dr. Thambi was reluctant to administer anesthesia to patients with head injuries. However, the evidence does not establish that on the morning of September 15, 1991, Dr. Thambi was told to administer anesthesia to Sean Crum or Delmar Mills by either Respondent, in his capacity as the on-call surgeon, or by Pat White, in her capacity as ARH's house supervisor. I find it very likely that the actions and inactions of Dr. Thambi, Respondent, and Pat White on September 15, 1991, were driven by ARH's longstanding policy to transfer all patients with head injuries.

The evidence introduced by both parties shows that, in September 1991, ARH had a practice of transferring all patients with head injuries to another medical facility. Denise Smith, R.N., was called to testify by Respondent. Her credentials include being Board Certified in conducting utilization reviews, having worked at ARH for eight years (including 1991), having worked in ARH's emergency room when extra help was needed, and having been in charge of all operations at ARH as the house supervisor during various shifts and on weekends. Tr. 734 - 36. Ms. Smith testified that ARH transferred all patients with head injuries during the eight years she worked there. Tr. 746. Judy Hatfield, the registered nurse who was working in the emergency room during the morning of September 15, 1991, testified also that ARH's practice, for the two years she worked there, was to transfer all patients with head injures to other facilities. Tr. 752. Dr. Thambi testified also that there was an unwritten policy in the anesthesiology department of ARH

against providing anesthesia to patients with neurological problems. Tr. 285 - 86. Dr. Thambi said that, during all his time at ARH, he had never dealt with a patient with neurological injuries who was given abdominal surgery. Tr. 286. He had worked with Respondent since 1983, and together they had done approximately 50 cases per year between 1984 and 1991. Tr. 249 - 50. Respondent did not cite one instance in which he had performed surgery of any type at ARH on a patient with a head injury.

Given ARH's longstanding policy to transfer all patients with head injuries, I cannot reject the explanations provided by Dr. Thambi concerning why he did not go to ARH for approximately two and one half hours after having received an initial phone call from a nurse. Dr. Thambi testified that he received only two phone calls from ARH during the morning in question: the initial call from a nurse (probably Pat White), at between 4:00 AM to 4:30 AM, and a later one from Respondent, at approximately 6:40 AM. Tr. 874 - 76T.[32] Dr. Thambi testified that he did not go to ARH in response to the first telephone call because he had told the nurse caller that all patients with head injuries were to be transferred from ARH without regard for their other problems, and the nurse caller appeared to have accepted his explanations. Tr. 875.

Given ARH's longstanding policy to transfer all patients with head injuries, I also cannot reject Dr. Thambi's testimony that, after he arrived at ARH in response to Respondent's telephone request at approximately 6:40 AM, Respondent appeared uninterested in, or not serious about, doing abdominal surgery. Tr. 257 - 59.

In this case, what happened to Sean Crum and Delmar Mills was precisely the result which would have been achieved had there been a conscious effort by everyone involved with the two patients' care at ARH to apply ARH's longstanding policy: the transfer of these two patients to another facility without having performed abdominal surgery on them at ARH because they had head injuries. Expressing a need to do surgery at ARH on these two patients, and then taking the actions necessary to actually perform surgery on these two patients, would have been contrary to ARH's longstanding transfer policy. Therefore, it seems logical that there should exist some documentation describing the details of the efforts to secure Dr. Thambi's services for surgery, and the responses from Dr. Thambi when the alleged actions of the

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[32] There is no dispute that he went to the hospital within 15 minutes of the 6:40 AM phone call.

surgeon and the emergency room staff[33] (if believed) would constitute an unprecedented deviation from ARH's longstanding policy of transferring all patients with head injuries to other facilities.

In addition, I expected detailed documentation to exist, due to the seriousness of the events alleged by Respondent and Pat White. The evidence before me establishes that it would be extremely unusual for any anesthesiologist to refuse to administer anesthesia when directed to do so by a surgeon. See, e.g., Tr. 112, 169, 173, 924; I.G. Ex. 10. Therefore, even disregarding ARH's longstanding transfer policy, just the sheer magnitude and unprecedented nature of the events alleged by Respondent and Pat White should have caused them to make detailed written summaries of what took place and when.

Yet, what Pat White wrote shortly after the incident concerning the chronology of contacts with Dr. Thambi and his responses to those contacts on the morning of September 15, 1991, consisted primarily of those brief summaries provided by Respondent. E.g., I.G. Ex. 4. What Respondent recorded consisted of very cursory summaries of responses attributed to Dr. Thambi, without setting forth the context of what Dr. Thambi was told or was asked to do by Respondent. E.g., I.G. Ex. 2 at 17. Even though Respondent contends that Dr. Thambi refused to administer anesthesia, he admitted that there exists no document showing that Respondent directed Dr. Thambi to do so. Tr. 926.[34]

Even though making notes of their contacts with Dr. Thambi should not have been a top priority for either Respondent or Pat White while they were in the emergency room on the morning of September 15, 1991, there were other opportunities to document their alleged efforts and results. I note, for example, that Pat White prepared an incident report for ARH shortly after the events in issue. In this incident report, she did not mention any repeated telephone calls for Dr. Thambi to come and administer anesthesia. I.G. Ex. 4. When an investigation was conducted of the charges that Sean Crum and Delmar Mills had been transferred in violation of federal law, there was no mention of any repeated telephone calls to

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[33] The evidence on whether the operating room crew had been called to ARH while awaiting Dr. Thambi's arrival consisted of witnesses' recollections given nearly five years after the alleged event. E.g., Tr. 480, 543, 860.

[34] Respondent appears to rely on the fact that in choosing the word "refused," he was implying that an order had been given to Dr. Thambi. Tr. 926.

Dr. Thambi, or any allegation that Dr. Thambi had failed to arrive timely in response to those repeated phone calls. See I.G. Ex. 1.

In addition, if Dr. Thambi had, indeed, refused or failed to appear within a reasonable time to help provide the necessary stabilization treatment, ARH was required by law to forward Dr. Thambi's name and address to St. Mary's Hospital. Section 1867(c)(2)(C) of the Act. Since Respondent is the one who alleges that he was unable to do the necessary stabilization surgery due to Dr. Thambi's failure or refusal to administer anesthesia, it was incumbent upon Respondent to make sure that said information (if true) was conveyed as required by law. Yet, neither Respondent nor ARH sent any such information to St. Mary's Hospital, and there is no evidence that Respondent or Pat White urged that such information be sent. In fact, the "Emergency Services Transfer Record" forms completed by Pat White under Respondent's directive contain the following item:

> List name and address of any on-call physician who failed or refused to appear within a reasonable period of time after being notified:

I.G. Ex. 2 at 9; I.G. Ex. 3 at 8 - 9. This item was left blank in the transfer forms for both Sean Crum and Delmar Mills. Id.

At the time of the transfers at issue, Respondent had the additional incentive to provide detailed documentation of all his cases pursuant to a settlement agreement he had reached with the Kentucky Board of Medical Licensure. I.G. Ex. 16 at 5 - 8. The I.G.'s evidence shows that, in order to resolve the complaint brought by the Kentucky Board of Medical Licensure concerning Respondent's treatment or care of 81 patients, Respondent had agreed to the terms of a Corrective Action Plan, which required Respondent to, inter alia, indicate with specificity "the physician's plan for treatment" and to attend scheduled continuing medical education courses "specifically addressing the preparation of medical records and hospital charts." Id. at 6, 7. Respondent entered into this agreement with the State in July of 1990. Id. at 5.

In deciding whether Dr. Thambi had failed to appear timely or had refused to administer anesthesia at any time prior to the patients' transfers, I find it significant also that Respondent was ARH's Chief of Surgery and Chief of Staff during the relevant period of time. Tr. 937. There is no evidence that, prior to September 15, 1991, he had ever voiced any objection to ARH's longstanding policy of transferring all patients with head injuries without treating their other medical conditions. It is difficult to believe that, on the morning of September 15, 1991, Respondent

decided to perform operations contrary to ARH's longstanding transfer policy, but did not consider it necessary to document, in detail, his reasons for proceeding against said policy. Nor did Respondent, in his capacity as the on-call surgeon, as the Chief of Surgery, or as the Chief of Staff, file any formal complaint against Dr. Thambi concerning the events of September 15, 1991. Tr. 936.[35] Respondent's failure to file any complaint against Dr. Thambi concerning the events of September 15, 1991, is remarkable also because, according to Respondent, he (in his capacity as ARH's Chief of Surgery) had previously told Dr. Thambi that he must change his conduct by responding to calls in a more timely manner. Tr. 938 - 39. According to Respondent, a written reprimand letter would have been issued by the Executive Department if Dr. Thambi had failed to change his ways. Tr. 940. (In his additional capacity as ARH's Chief of Staff, Respondent was the Chairman of the Executive Committee. Tr. 941.) Yet, no letter of reprimand was issued by the Executive Committee Respondent chaired, even though Respondent now complains that Dr. Thambi had, after warning, failed to respond timely to calls on September 15, 1991. See Tr. 937, 987 - 88**T**.

I think it significant also that, on the morning of September 15, 1991, Pat White was the Relief House Supervisor and, therefore, in charge of the entire hospital. Tr. 476 - 77. It does not appear likely that, in said capacity, she would have assisted in any unprecedented deviation from ARH's longstanding transfer policy without providing detailed explanations of the circumstances and reasons for doing so at, or shortly after, the time of the events. Yet, as noted earlier, the documents she generated, after the fact, were either cursory in nature or did not contain the information she now alleges.

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[35] C.D. Glover, ARH's Administrator at the time of the incidents, testified that he approached Respondent and other doctors involved in the transfers after having received the complaint from St. Mary's Hospital. Tr. 988 - 89**T**. According to Mr. Glover's testimony, Respondent did not initiate any oral complaints about Dr. Thambi's conduct.

Respondent said he had spoken to ARH's Administrator about the problems with Dr. Thambi on September 15, 1991, even before the Administrator had approached him. Tr. 936. However, there is no documentation of Respondent's alleged oral communication with the Administrator, and Respondent never filed a complaint which would have instigated an investigation by the appropriate department concerning whether disciplinary action against Dr. Thambi was necessary. Tr. 936; see Tr. 937 - 42.

Pat White's position as the Relief House Supervisor on the morning in question is significant also because, if Dr. Thambi had, in fact, done or failed to do what is now being alleged, Pat White had the authority to take significant actions against Dr. Thambi in her capacity as the Relief House Supervisor in charge of ARH that morning. However, in her capacity as the Relief House Supervisor in charge of ARH, she has never filed any complaint against Dr. Thambi alleging that he failed to respond to phone requests timely, or refused to administer anesthesia when requested to do so on September 15, 1991.

Even though Pat White testified at the hearing that she witnessed Dr. Thambi's refusal to administer anesthesia after he had arrived at the emergency room (Tr. 487), I do not find this testimony credible. This alleged event was not recorded by Pat White in any document she generated on or shortly after September 15, 1991. In addition, there is no evidence indicating that, as the Relief House Supervisor in charge of ARH that morning, she ever told Dr. Thambi that he should administer anesthesia if Respondent told him to do so.[36] Nor did Pat White allege that Respondent had asked her, in her capacity as the Relief House Supervisor in charge of ARH on September 15, 1991, to instruct Dr. Thambi to provide services as Respondent directed. Whether or not a hospital official has the authority to demand or order an anesthesiologist to administer anesthesia in a particular case (see Tr. 980T), a hospital official can be reasonably expected to take actions to affirmatively support a surgeon's orders to an anesthesiologist (see Tr. 987 - 88T), especially when the allegation is that the lives of patients with emergency medical conditions have been jeopardized by the anesthesiologist's failure or refusal to act. As pointed out also by Dr. Thambi, the utterance of the head of a hospital has weight in these situations, since the physicians are given privileges to practice by the hospital. Tr. 262. According to Pat White, what she did while Delmar Mills and Sean Crum were in ARH's emergency room was to make some brief phone calls to Dr. Thambi to say that Respondent needed him (e.g., Tr. 482 - 84), in addition to having attempted to secure alternative anesthesiology services and to contact ARH's Administrator (Tr. 489 - 90). Pat White testified at the hearing that she had attempted to call ARH's Administrator at his home, but was told that he was out of

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[36] Pat White testified that she heard Respondent say to Dr. Thambi, after Dr. Thambi's arrival at ARH, "John . . . I have to do surgery, I have to have anesthesia, I have to do surgery." Tr. 487. Even if these words could be interpreted as Respondent's directive ordering Dr. Thambi to administer anesthesia, the truth of Pat White's testimony is contradicted by the fact that she has never documented this incident or alleged it prior to the hearing.

town. Tr. 535. However, she does not remember whether she attempted to call the Assistant Administrator, who would have been the person in charge of the hospital in the Administrator's absence; she did not contact the Nursing Supervisor, the next ARH official in the chain of command, until later the following day. Id.

Pat White's lack of action commensurate with her authority as the Relief House Supervisor in charge of the entire hospital that morning is not consistent with the allegations that Dr. Thambi acted in contravention of his duty as an on-call anesthesiologist to appear timely at the hospital and to provide the services he was directed to provide by the surgeon. Nor is her failure to take action commensurate with her role as the Relief House Supervisor consistent with the theory that Sean Crum and Delmar Mills were transferred due to the unavailability of an anesthesiologist. Dr. Thambi, the on-call anesthesiologist, was within 15 minutes of ARH. The evidence fails to establish that either Respondent or Pat White took the actions necessary and appropriate to bring him into the hospital and have him administer anesthesia if directed to do so. Thus, I cannot conclude that no anesthesiologist was available for the two patients' abdominal surgery at ARH on the morning of September 15, 1991.

My decision to reject Respondent's version of his dealings with Dr. Thambi on September 15, 1991, reflects also my view that Respondent is not a credible witness. Even though the available evidence does not enable me to determine with certainty the contents of the conversations held between Dr. Thambi and Respondent on September 15, 1991, Respondent's testimony was so equivocal on related matters that I am not able to believe that he has given me an honest account of his exchanges with Dr. Thambi on the morning in question. For example, Respondent first admitted that, after he received notice of the I.G.'s position in this case during 1995, Respondent contacted Dr. Sakhai and told Dr. Sakhai that he (Dr. Sakhai) had accepted the transfers of Sean Crum and Delmar Mills. Tr. 916 - 17. Respondent then changed his testimony. Tr. 919 - 21. I note in addition that Respondent first testified to not being aware of any complaints filed against him concerning his professional activities or practices at ARH. Tr. 945 - 46. However, after consultation with his counsel, Respondent admitted that there were complaints against him. Tr. 951. Only after having been pressed for additional answers to more specific questions on this issue did Respondent admit that he had problems with the inappropriate admissions of one or two patients and that his privileges at ARH had been limited as a result of his having provided medically unnecessary pacemakers to patients. Tr. 951 - 63. Subsequently, the I.G. established, on rebuttal, that Respondent had notice of the complaints received by the Kentucky Board of Medical Licensure, in 1990 and thereafter,

concerning the care Respondent had rendered to numerous patients, including some at ARH. I.G. Exs. 16, 17. Respondent's lack of candor is shown also by the fact that, even though Respondent ultimately admitted that he had never obtained acceptance from Dr. Arya for the transfers of Sean Crum or Delmar Mills (e.g., Tr. 914, 928), Respondent had given testimony which conveyed the impression that Dr. Arya may have accepted the patients for transfer (e.g., Tr. 851). Such equivocal and misleading information provided by Respondent has caused me to doubt the truth of the facts he has asserted.

For the foregoing reasons, I do not find that Respondent's culpability for the unlawful transfers of Sean Crum and Delmar Mills has been lessened by the alleged unavailability of an anesthesiologist. Instead, the evidence shows that the failure of Respondent, as ARH's on-call surgeon, to direct Dr. Thambi to administer anesthesia to Sean Crum and Delmar Mills for the surgery Respondent thought was medically appropriate, resulted in ARH's failure, as well as in Respondent's failure, to provide the medical treatment within their capacity to minimize the risks to those patients' health prior to transfer. See section 1867(c)(2)(A) of the Act.

When the lives of patients hang in the balance, a surgeon in Respondent's position is not excused from making clear his directives to an anesthesiologist. Even Dr. Aaron, one of Respondent's expert witnesses, testified that it was Respondent's duty to speak to Dr. Thambi if there were ambiguities concerning the availability of anesthesia for surgery. Tr. 1009T. There is no evidence that the duty was on anyone other than Respondent to resolve such ambiguities. Accordingly, the record establishes that, on September 15, 1991, Respondent acted in dereliction of his statutory duties to Sean Crum and Delmar Mills by failing to specifically tell Dr. Thambi to administer anesthesia for a surgery Respondent felt was necessary; seeking to rely on the inferences which might have been created by Dr. Thambi's words or deeds; and acquiescing to ARH's longstanding unwritten policy to transfer all patients with head injuries.

These same facts and considerations have led me to reach the related conclusion that neither Respondent nor anyone else acting on behalf of ARH on the morning of September 15, 1991, fully or accurately explained ARH's obligations under section 1867 of the Act to the families of Sean Crum or Delmar Mills before persuading them that these patients should be transferred. See section 1867(c)(1)(A)(i) of the Act. Whereas Respondent has introduced the testimony of himself, Pat White, and Judy Hatfield, to support the contention that the patients' families were made aware of the risks of the transfers before they signed the transfer forms, there is no evidence that anyone informed these families that ARH had a

duty not to apply its longstanding transfer policy in the present case, or that ARH's duty to provide all the medical treatment within its capacity prior to a transfer included, if necessary, having the surgeon direct the anesthesiologist to administer anesthesia for any surgery the surgeon deemed appropriate.

In testifying about what he told the families of Sean Crum and Delmar Mills concerning the risks and benefits of transfer, even Respondent has not alleged that he ever told the families that it was his medical judgment to do abdominal surgery as soon as possible and that he would direct Dr. Thambi to administer anesthesia.[37] Respondent stipulated that he never made any effort to have the family members provide a written refusal of abdominal surgery at ARH. Tr. 934. Moreover, the evidence discloses no incentive for Respondent, or anyone else acting for ARH on September 15, 1991, to inform the two patients' families of the duty to perform abdominal surgery at ARH notwithstanding the head injuries and in lieu of effectuating ARH's longstanding transfer policy.

Based on the foregoing, I find that the parents of Sean Crum and Delmar Mills were not given accurate or complete information concerning ARH's duties under section 1867 of the Act. The families were not told the true reasons (e.g., ARH's longstanding transfer policy, Respondent's failure to direct Dr. Thambi to administer anesthesia) why they were being approached for consent to transfer their sons. Therefore, I give no legal effect to the fact that they signed an acknowledgement stating that they had been "fully informed of . . . [ARH's] obligation to provide appropriate medical care within the capability of the services provided by the hospital and to affect a transfer for services unavailable at the hospital." I.G. Ex. 2 at 10; I.G. Ex. 3 at 10.

I conclude from my review of the evidence that there exists no legitimate reason why a surgeon in Respondent's position on September 15, 1991, could not or should not have fully advised the families of the foregoing duties imposed by statute when he was discussing the risks and benefits of transfers with the families. In fact, if Respondent had thought that Dr. Thambi was being uncooperative, there was no one in a better position than Respondent to explain to the families his reasons for failing or refusing to direct Dr. Thambi to provide anesthesia, so that all the medical

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[37] Respondent's testimony indicates that it was not until shortly before the hearing that Respondent first alleged to the families that the reason no surgery was performed at ARH was because Dr. Thambi had refused to administer anesthesia. See Tr. 971.

treatment within ARH's capacity might be provided prior to transfer, in order to minimize the health risks to Sean Crum and Delmar Mills.

Therefore, the facts relevant to Respondent's allegations concerning Dr. Thambi's actions established not the mitigation of Respondent's culpability, but that, through Respondent's misconduct and derelictions of his duties, the transfers were effectuated without compliance with section 1867(c)(1)(A)(i) of the Act. The families of Sean Crum and Delmar Mills were not fully or truthfully informed of ARH's obligations under the statute, or of Respondent's reasons for having them transferred to St. Mary's Hospital. Respondent was responsible for said noncompliance.

In order for me to conclude that there was noncompliance with section 1867(c)(1)(A) of the Act, the evidence must establish a failure to comply with all three alternative provisions contained therein. In Section III, I have already found that Respondent was responsible for having caused Sean Crum and Delmar Mills to be transferred in the absence of any physician's having signed or counter-signed the certification specified by section 1867(c)(1)(A)(ii) or (iii) of the Act. Adding those findings to my preceding determinations under section 1867(c)(1)(A)(i) of the Act means that Respondent was responsible for the failure to comply with section 1867(c)(1)(A) of the Act.

For other reasons I have discussed previously, Respondent was also responsible for the transfers of Sean Crum and Delmar Mills when their transfers did not meet the definition of an "appropriate transfer" incorporated by section 1867(c)(1)(B) of the Act. I have detailed my reasons for concluding that the "appropriate transfer" definition was not met in this case because ARH did not provide the medical treatment within its capacity to minimize the health risks to Sean Crum and Delmar Mills (see section 1867(c)(2)(A) of the Act), and because St. Mary's Hospital had not agreed to accept the transfer of these two patients. See section 1867(c)(2)(B)(ii) of the Act.

Accordingly, Respondent's culpability extends to the violations which have occurred under section 1867(c)(1)(A)(i), (ii), (iii), and under section 1867(c)(1)(B)'s incorporation of section 1867(c)(2)(A) and (B)(ii).

Section X

In this section, I discuss my reasons for having found and concluded as follows:

> **53. The I.G. has determined the amounts of the CMPs at issue based upon an evaluation of the factors specified by 42 C.F.R. § 1003.106(a)(4).**
>
> **54. Respondent has not submitted any arguments to show that the amount of the CMPs assessed by the I.G. are unreasonable (or what amount would be reasonable), or that the evidence in this case should be weighed differently to attain a different amount.**
>
> **55. I find reasonable the CMP amounts assessed by the I.G. against Respondent:**
>
> > **A. $50,000 for the violation of section 1867 with respect to Sean Crum;**
> >
> > **B. $50,000 for the violation of section 1867 with respect to Delmar Mills.**
>
> **56. The CMP amounts assessed by the I.G. have not been made unreasonable by the evidence showing that Sean Crum was near death at ARH and did later die from his brain injuries, after having undergone abdominal surgery at St. Mary's Hospital.**
>
> **57. The CMP amounts assessed by the I.G. have not been made unreasonable by the evidence showing that Delmar Mills recovered, after having been transferred to St. Mary's Hospital.**

In her post-hearing brief, the I.G. argued that the facts in this case illustrate "a complete collapse of emergency medical care for two individuals with very critical medical conditions." I.G. Br., 96. I agree. The facts discussed above indicate also that Respondent was the primary, if not the sole, cause of the collapse.

Because the patients needed surgery and Respondent was the on-call surgeon, Respondent was the de facto "captain of the ship" for making decisions which were based on those patients' surgical needs. Section 1867 of the Act was violated only after the two patients' need for surgery became known to Respondent. The collapse of emergency medical care for two very critically injured individuals occurred because Respondent failed to take the legally required actions necessitated by his role as a surgeon and by the patient's unstable emergency medical conditions.

For each of the elements of section 1867(c) that were violated in this case, Respondent was the individual in the best position (if not the sole position) to take the actions necessary to avoid its violation. FFCL 1 - 52. For example, if Respondent had issued clear and unequivocal directives to Dr. Thambi to provide anesthesia, Respondent would have had no excuse to avoid performing the necessary abdominal surgery or to suggest transfers to the parents of the patients based on an inaccurate or incomplete explanation of ARH's duties under section 1867(c)(1)(A)(ii) of the Act. If Respondent had performed the abdominal surgery necessary to stabilize the patients' emergency medical conditions, there would have been no occasion to violate the requirements for effectuating an "appropriate transfer" within the meaning of section 1867(c)(2)(A) or (B)(ii), as had occurred in this case. If Respondent had performed the stabilization surgery needed by the patients, there also would not have been the occasion to violate the physician certification requirement specified in section 1867(c)(1)(A)(ii) and (iii), as occurred here.

The facts of this case do not suggest that it would have been difficult for Respondent to avoid the violations of section 1867(c) which have occurred. Respondent was a surgeon, and he was called in by ARH to provide appropriate surgical services. He and Dr. Thambi had known and worked together for many years prior to September 15, 1991. Even if Respondent was in doubt about Dr. Thambi's willingness to administer anesthesia, Respondent had the opportunity and means to act in the patients' best interest as required by law. There was no reason why Respondent could not have directed Dr. Thambi to provide anesthesia to Sean Crum or Delmar Mills, if Respondent had truly wanted to perform surgery on September 15, 1991. The evidence of record does not establish that Dr. Thambi probably would have refused a direct order from Respondent, the on-call surgeon. Thus, with a few clearly articulated words to Dr. Thambi, Respondent could have ensured against the violations under review here.

Even though ARH's longstanding unwritten policy was to transfer all patients with head injuries, Respondent was not required to follow the policy. There is no evidence that such a policy was enforceable by ARH,[38] or that any physician would suffer adverse consequences if the physician deviated from it. Under the facts of this case, application of this unwritten policy was unlawful. Respondent knew that it was medically necessary for the two patients to have surgery immediately. Yet, he choose to take actions that were consistent with ARH's transfer policy.

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[38] As a matter of law, the policy is unenforceable by ARH if its application results in a statutory violation.

Even accepting Respondent's argument that ARH's emergency room was very busy, that Respondent was caring for multiple patients on September 15, 1991, and that Respondent might have thought that Dr. Thambi was uncooperative, it would not have taken an undue amount of effort or time for Respondent to order Dr. Thambi to administer anesthesia. Even if busy, a surgeon should exercise due diligence to avoid the collapse of emergency medical care for patients who need surgical services. In this case, Respondent had approximately four to five hours to direct Dr. Thambi to administer anesthesia to Sean Crum and Delmar Mills. The evidence shows that Respondent decided as early as 4:00 AM to have the patients transferred, without having ever taken the few seconds necessary to direct Dr. Thambi to administer anesthesia. Ordering Dr. Thambi to administer anesthesia would have triggered compliance (instead of noncompliance) with section 1867 of the Act.

The evidence shows also that, not only did Respondent violate and cause to be violated the various elements of section 1867(c) of the Act, he has attempted repeatedly to shift his responsibilities away from himself during September 15, 1991 and thereafter. I note, as an example, the evidence discussed previously concerning Respondent's having written "advice" to Dr. Hani to secure authorization for the transfers, even though Respondent knew that Dr. Hani was opposed to the transfers. I note, as further examples, the evidence discussed previously concerning Respondent's denial that he had instructed Pat White to effectuate the transfers by filling out the necessary forms and placing his name on them, his excuse at hearing that surgery was not done because Dr. Thambi was not available, and his calling up Dr. Sakhai years later to suggest that Dr. Sakhai had accepted the transfers. The circumstances under which the statutory violations occurred shows that, on and after September 15, 1991, Respondent has been only too ready to blame others as a means for covering up his unlawful acts and omissions.

According to the I.G.'s notice letter, a CMP totaling $100,000 ($50,000 for the violation pertaining to Sean Crum and $50,000 for the violation pertaining to Delmar Mills) has been assessed again Respondent. The I.G.'s notice explained how this amount was calculated, based on the factors specified in 42 C.F.R. § 1003.106(a)(4). According to the I.G.'s notice, the amount reflects the "substantial" degree of Respondent's culpability, the aggravating nature and circumstances of the violations, and the "significant costs" incurred by the Department of Health and Human Services in this case. Notice letter, 2 - 3. The I.G. noted that she was not aware of any prior offense by Respondent in similar situations, and that Respondent's financial condition was not considered a mitigating factor since Respondent had declined the opportunity to make known any financial problems he might be having. Id. at 2.

Based on my evaluation of the evidence relevant to those factors relied upon by the I.G. in calculating the CMP, I agree that the amount of $50,000 is reasonable for the violation pertaining to Sean Crum. I agree also that the amount of $50,000 is reasonable for the violation pertaining to Delmar Mills. It is difficult to imagine a more egregious set of circumstances under which the two patients' rights, as well as the public's interests under section 1867 of the Act, could have been breached. There was no individual more responsible than Respondent for violating the public's interest and the two patients' rights under section 1867 of the Act. Moreover, the violations of the many elements of the statute were so easily avoidable by Respondent. Instead of avoiding the occurrence of these violations by simply taking the actions required by his duties as the on-call surgeon, Respondent caused one element after another of section 1867 to be violated on September 15, 1991.

However, Respondent maintained, even in his post-hearing Reply Brief, that he was "sinned against and not the sinner." R. Reply, 1. His persistence in placing blame on others shows that he is without remorse and without any sense of responsibility for the violations he caused. His lack of candor in recounting past events is an additional indicator of his untrustworthiness.

Therefore, it is unlikely that a CMP amount of less than $50,000 per violation will suffice to protect the public interest or the health of other patients with emergency medical conditions under section 1867 of the Act.

In upholding the CMP amount assessed by the I.G., I note also that Respondent has not submitted any arguments to show that the CMP amount calculated by the I.G. is unreasonable, or that the evidence relevant to the factors relied upon by the I.G. in reaching the CMP amounts should have been weighed differently. Respondent has also persisted in providing no proof of his financial situation. Nor has Respondent indicated what CMP amount would be reasonable in his view.

However, Respondent alleged in his post-hearing brief that, at ARH, Sean Crum was "brain dead and several days later expired of his head injury." R. Br., 2. At the hearing, several physicians called by Respondent to testify have stated their opinion that Sean Crum would have died from his head injuries even if abdominal surgery had been done at ARH. For example, Dr. Sakhai, a neurosurgeon with 35 - 40 years of experience (Tr. 331 - 32, 350), testified that Sean Crum had less than a one percent chance of recovery, given his signs and symptoms at ARH and, therefore, there was no benefit to transferring Sean Crum. Tr. 355. Dr. Aaron gave essentially the same opinion in noting that, if medical resources had been limited, then there would have been a decision made concerning the allocation of those resources to others with a

better chance of recovery, based on the fact that Sean Crum was to have a short life "in terms of hours" due to his brain damage. Tr. 416; see 430.

If Respondent is seeking to rely on this line of evidence to implicitly argue that the amount of the CMP is unreasonable, I note several problems with said approach under the facts of this case. First, neither Sean Crum's prognosis, nor Delmar Mills' prognosis, has been factored into the I.G.'s calculation of the CMP amount. The CMP has not been imposed because Sean Crum died despite the abdominal surgery performed at St. Mary's Hospital, or because, after being transferred, Delmar Mills was found to have needed only abdominal surgery and not neurological surgery. See I.G. Ex. 2 at 15; I.G. Ex. 3 at 22. The CMP is not being assessed as compensation to the patients' families for any losses they might have sustained as a consequence of Respondent's actions.

Additionally, as Dr. Hannigan correctly emphasized in his testimony, Sean Crum was not brain dead when he was brought to ARH. Tr. 79. Sean Crum did have vital signs (i.e., blood pressure, pulse, respiration, and temperature) at ARH. Tr. 65 - 66. As discussed in Section I of this decision, there is no disagreement among the experts that, even given severe head injuries, abdominal surgery should have been performed first under the "ABC" protocol. As Dr. Hannigan pointed out, "Advanced trauma life support is a national standard[,] and to deviate from it, you are only buying trouble." Tr. 119. I agree also with Dr. Hannigan's opinion that a physician has a duty to continue with resuscitative efforts on a trauma patient with vital signs when the physician does not know whether the patient will improve or not. Tr. 65 - 66.

In this case, Respondent did not have Dr. Sakhai's expertise or experience as a neurosurgeon in assessing Sean Crum's chance for recovery. Nor did Respondent make any resource allocation judgment that Dr. Aaron thought would be permissible. To the contrary, Respondent claimed that he devoted his attention first to Sean Crum, because Sean Crum was "the one [who] need[ed] more help to make it than Delmar Mills." Tr. 843. Respondent testified that Sean Crum's brain was not dead and that he (Respondent) was trying to help Sean Crum improve his vital signs. Tr. 844. Respondent never contended that he failed to perform abdominal surgery on Sean Crum because he felt that it was more appropriate to devote available medical resources to Delmar Mills based on the two patients' relative chances for recovery. Except for alleging that anesthesia was not available, Respondent has not asserted any claim that abdominal surgery could not have been performed on both patients during the four to five hours they were at ARH.

For these reasons, I do not find merit in Respondent's intimations that the CMP amounts might be unreasonable because Sean Crum died at St. Mary's Hospital from his brain injuries, or because Delmar Mill recovered after his transfer.

Section XI

In this section, I explain my reasons for having found and concluded as follows:

> **58. The I.G.'s notice letter to Respondent stated that an exclusion of two years was being imposed due to the repeated nature of Respondent's violations.**
>
> **59. Respondent's violations of section 1867 of the Act with respect to Sean Crum and Delmar Mills cannot fairly be considered repeated in nature.**
>
> **60. The I.G. did not provide notice prior to hearing that, to support the exclusion in controversy, she had made an additional determination that Respondent's violations under section 1867 of the Act were also "gross and flagrant."**
>
> **61. Even if the timing of the I.G.'s notice on her "gross and flagrant" determination constituted harmless error, the evidence does not provide adequate support for the I.G.'s contention that Respondent's violations under section 1867 of the Act were "gross and flagrant."**
>
> **62. Under the facts of this case, the I.G. had no basis for proposing an exclusion against Respondent.**

The I.G. may impose an exclusion against Respondent if the violations under consideration were repeated or were "gross and flagrant," as defined by 42 C.F.R. § 1003.105(a)(1)(C). Section 1867(d)(1)(B) of the Act.

In her notice letter, the I.G. stated that Respondent would be excluded from participation in the Medicare and State health care programs for a period of two years due to the repeated nature of his violations under section 1867 of the Act. Notice Letter, 3. However, during his opening statement, counsel for the I.G. represented that the exclusion is merited also because Respondent's violations were gross and flagrant. Tr. 11. In her post-hearing brief, the I.G. requested a specific finding that Respondent's

violations were "gross and flagrant" within the meaning of the law. I.G. Br., Finding 126 at 12; see I.G. Br., 98 - 101.

I conclude from my review of the evidence that Respondent's violations with respect to Sean Crum and Delmar Mills cannot be fairly considered to have been "repeated" in nature. The I.G.'s conclusion on the "repeated" issue is based solely on the fact that Respondent violated section 1867 of the Act with respect to two patients and that the violations occurred over a period of four hours. I.G. Br., 101. However, the violations with respect to both patients resulted from nearly identical actions, taken under nearly identical circumstances, during essentially the same segments of time. Respondent's actions and inactions with respect to both patients were without material difference. Even though there is some small degree of time lapse between when the different elements of the statute were violated with respect to each patient, the time differences appear to have resulted naturally from people's need to speak, act, or write in sequence.

In addition, the evidence of record showing that ARH's emergency room was unusually busy during the morning of September 15, 1991, may also help to explain the variations in time between the actions taken with respect to the two patients. There is no evidence indicating, for example, that Respondent contemplated the first violation before deciding to commit another violation. There is also no evidence that the use of separate ambulances to transport Sean Crum and Delmar Mills to St. Mary's Hospital was anything other than routine procedure when staff and supplies needed to accompany each patient.

For the foregoing reasons, I do not find the existence of repeated violations as alleged by the I.G.

I reject also the I.G.'s assertion of a "gross and flagrant" theory both at the hearing and in her post-hearing brief. First, Respondent was not placed on notice by the I.G. prior to the hearing that she would be seeking to prove the basis of the exclusion based on the theory that the statutory violations were "gross and flagrant." Even if I could construe the absence of such advance notice to be harmless error, the evidence is not sufficient to sustain the I.G.'s use of a "gross and flagrant" theory to support the imposition of a two-year exclusion.

The regulation defines a "gross and flagrant" violation as one which presents an imminent danger to the health, safety, or well-being of the individual who seeks emergency examination and treatment or places that individual unnecessarily in a high risk situation.

42 C.F.R. § 1003.105(a)(1)(C). Even though I have found the circumstances of the violations under consideration to be egregious and avoidable by Respondent, it does not follow automatically that the statutory violations therefore presented imminent danger to the health, safety, or well-being of Sean Crum and Delmar Mills, or that those two individuals were unnecessarily placed in a high risk situation by the statutory violations. I think it important to emphasize also that my earlier discussions of the two patients' stability at the time of their transfer does not imply that the violations committed by Respondent meet the definition of "gross and flagrant."

As discussed previously, the evidence is conflicting as to whether Sean Crum and Delmar Mills had become stable within the meaning of the statute prior to transfer. I found section 1867(c) of the Act, titled "Restricting Transfers Until Individual Stabilized," to be applicable to this case because Respondent and Dr. Hani in ARH's emergency room made "unstable" determinations on the morning of September 15, 1991, and those determinations (whether or not they are subject to disagreement in hindsight) triggered the assumption of certain duties under the statute. I found violations under section 1867(c) of the Act because Respondent failed to assume those duties necessitated by his determinations that the patients had not become stable within the meaning of the law.

In addition, there are various facts which make the determination of "gross and flagrant" in this case more complicated than what the I.G. has proposed: that Respondent's violations should be considered "gross and flagrant" with respect to both patients because, without the abdominal surgery Respondent should have performed, there is evidence that both patients could have died from continued bleeding en route to St. Mary's Hospital. I.G. Br., 99 - 101.

The two violations in this case resulted from multiple acts and omissions which took place over a period of approximately five hours. As discussed above, the record evidence showed that, even though they never received abdominal surgery during the five hours they were at ARH, the two patients did receive non-surgical intervention which caused their blood pressure readings to improve. Therefore, their medical conditions due to abdominal trauma did not remain static while they were at ARH. Also, the injuries of these two patients were not identical, and the seriousness of their overall medical conditions were not the same. Several doctors testified that Sean Crum would have died from his head injuries even if abdominal surgery had been performed at ARH. (St. Mary's Hospital's records show that he did, in fact, die from his brain injuries after undergoing abdominal surgery there.) I think it significant also that both

patients arrived at ARH after having been critically injured in an automobile accident. They were taken away from ARH by ground ambulance due to weather conditions which made helicopter transport impossible, as the I.G. stipulated at hearing. Tr. 982.

These foregoing facts were not adequately addressed by the I.G. in arguing that the violations were "gross and flagrant" within the meaning of the statute.

Moreover, even though the record evidence shows that some danger and some unnecessary risks to the patients' health were created by Respondent's having caused them to be transferred without having first performed abdominal surgery, the evidence does not establish that the dangers were imminent or that the risks were high. In questioning the multiple medical experts called to testify at the hearing, the I.G. never asked one of them to render an opinion under the regulatory definition of "gross and flagrant." Without the aid of credible expert medical opinions on these issues, I can only speculate on whether, when, and which of Respondent's acts or omissions might have placed either patient in a high risk situation or whether the danger to their life or health was imminent. Even if there were some inferences to be drawn on the "gross and flagrant" issue from the medical experts' testimony on other matters, there is no preponderance of the evidence establishing the propositions urged by the I.G.

Therefore, the exclusion proposed by the I.G. lacks a proper evidentiary basis.

CONCLUSION

For the foregoing reasons, I uphold the CMP amounts proposed by the I.G. against Respondent ($50,000 for each of the two violations), and I set aside the two-year exclusion proposed by the I.G. against Respondent.

/s/

Mimi Hwang Leahy

Administrative Law Judge