Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the Case of:	)	
	)	
St. Joseph's Medical Center,	)	Date: January 30, 2009
	)	
Respondent,	)	
	)	
- v. -	)	Docket No. C-08-296
	)	Decision No. CR1895
The Inspector General.	)	
	)	

DECISION

I sustain the determination of the Inspector General (I.G.) to impose a civil money penalty of $50,000 against Respondent, St. Joseph's Medical Center, based on Respondent's noncompliance with the Emergency Medical Treatment and Labor Act (EMTALA), section 1867 of the Social Security Act (Act).

I. Background

Respondent is a hospital in Stockton, California. It participates in Medicare and has an emergency medical department (emergency room). The emergency room is subject to the requirements of EMTALA. On December 19, 2007, the I.G. notified Respondent that he had determined that Respondent had failed to comply with pertinent EMTALA requirements. The I.G. advised Respondent that, based on his determination of EMTALA noncompliance, he had determined to impose a civil money penalty of $50,000 against Respondent.

Respondent requested a hearing and the case was assigned to me for a hearing and a decision. The parties completed discovery and filed pre-hearing exchanges, including the written direct testimony of their proposed witnesses, pursuant to a pre-hearing order that I issued. I scheduled an in-person hearing. In advance of the hearing the parties advised me that they had agreed to try the case based on their written exchanges. Therefore, I accepted final briefs from the parties in lieu of conducting an in-person hearing.

The I.G.'s pre-hearing exchange included 21 proposed exhibits which the I.G. identified as I.G. Ex. 1 - I.G. Ex. 21. The I.G. attached an additional proposed exhibit to his final brief, I.G. Ex. 22. Respondent's pre-hearing exchange consisted of five proposed exhibits which Respondent identified as P. Ex. 1 - P. Ex. 5.[1] Neither party objected to my receiving any of the proposed exhibits into evidence and, so, I receive them.

II. Issues, findings of fact and conclusions of law

A. Issues

The issues in this case are whether:

1. Respondent contravened EMTALA; and

2. The I.G.'s determination to impose a $50,000 civil money penalty against Respondent is reasonable.

B. Findings of fact and conclusions of law

I make findings of fact and conclusions of law (Findings) to support my decision in this case. I set forth each Finding below as a separate heading.

1. Respondent contravened the EMTALA requirement that it provide an appropriate medical screening examination to an individual who requested treatment at Respondent's emergency room.

In relevant part EMTALA provides that:

> In the case of a hospital that has a hospital emergency department, if any individual . . . comes to the emergency department and a request is made on the individual's behalf for examination or treatment for a medical condition, the hospital must provide for an appropriate medical screening examination within the capability of the hospital's emergency department . . . to determine whether or not an emergency medical condition . . . exists.

Act, section 1867(a).

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[1] Respondent's exhibit identification of "P. E.x." is based on its self-reference as "Petitioner." I am not changing this identification although I refer to Respondent as "Respondent" and not "Petitioner" throughout this decision.

The I.G. bases its allegation that Respondent contravened this EMTALA requirement on the care that Respondent provided, on the evening of December 29, 2001, to an individual whom I identify as "AP." The evidence presented by the I.G. establishes that AP waited for about three hours at Respondent's emergency room on the evening of December 29, 2001, without being examined by a physician to determine the reason for his complaints and his medical signs. During that three-hour period, AP's condition deteriorated steadily. He manifested signs of a life-threatening emergency medical condition. AP's family repeatedly pleaded with Respondent's emergency room staff to take notice of and to address his problems. Their pleas were unavailing. Respondent's staff did not begin to deal with AP's problems until AP had deteriorated irretrievably. Eventually, AP died.

AP was an elderly individual, aged 88, who was brought to Respondent's emergency room at 5:41 p.m. on the 29th by members of his family. AP's daughter-in-law told the emergency room registration clerk that AP was not feeling well and that his physician had directed that he be brought to the emergency room. I.G. Ex. 11, at 3; I.G. Ex. 12, at 2. AP's complaints and possible problems were recorded on the emergency room log as being "general weakness/possible stroke." I.G. Ex. 13, at 2.

AP and his family members then went to the emergency room waiting area to await examination and possible treatment. His condition appeared to be deteriorating and on separate occasions his daughter-in-law and son reported at the registration window that AP's condition was getting worse and that he needed to be seen by a physician. I.G. Ex. 12, at 3; I.G. Ex. 14, at 4. At 7:06 p.m. on the 29th AP was called to meet with Respondent's triage nurse. I.G. Ex. 7, at 1. The triage nurse took AP's blood pressure, which was recorded at 107/44, his pulse, which was recorded at 55 beats per minute, and his blood oxygenation level, which was recorded at 93 percent. I.G. Ex. 7, at 1. While being seen by the triage nurse AP was noted by his family members as appearing to be pale. I.G. Ex. 11, at 3. On the triage form the triage nurse noted AP's complaints as including general weakness, decreased appetite, a swollen tongue since the previous day (December 28, 2001), and slurred speech. I.G. Ex. 7, at 1. In fact, AP's tongue had swollen to the extent that AP was unable to speak, and the triage nurse was unable to take his temperature due to the swelling. I.G. Ex. 12, at 3. The triage nurse noted: "tongue swollen is taking Naproxen." I.G. Ex. 7, at 1.

The triage nurse classified AP as "routine" meaning, in effect, that he did not need to be seen immediately by a physician. I.G. Ex. 7, at 1; I.G. Ex. 15, at 3; *see* I.G. Ex 12, at 3. The triage nurse told AP and his family to return to the waiting area and that someone would call AP shortly. I.G. Ex. 11, at 4; I.G. Ex. 12, at 3.

AP's condition appeared to deteriorate as he awaited an examination and treatment. He complained of back pain, his lips began to turn blue, and he had trouble breathing. I.G. Ex. 11, at 4; I.G. Ex. 12, at 3-4. Several times members of AP's family told Respondent's registration clerk that AP's condition was deteriorating and that he needed to be seen by a physician. I.G. Ex. 12, at 3-4. At around 8 p.m. on that evening, AP's daughter-in-law pushed through the door to the triage area and told the nurse that AP might be having a heart attack. I.G. Ex. 11, at 5. At about the same time, the registration clerk called the nursing station and advised Respondent's staff that AP's family had reported that AP was having difficulty breathing. I.G. Ex. 7, at 3.

AP was taken to an examining room at about 8:15 p.m. The emergency room charge nurse instructed a technician to put AP on a cardiac monitor and to administer oxygen to him. I.G. Ex. 14, at 9. However, these instructions were not followed. I.G. Ex. 11, at 5-6; I.G. Ex. 12, at 4; I.G. Ex. 14, at 9.

AP waited to be seen for about an additional one-half hour. At that point he began to demonstrate serious breathing problems. I.G. Ex. 11, at 6. His family members ran to get help. A nurse came into the examining room at about 8:50 p.m., observed AP's condition, and declared a "code blue" situation, meaning that AP needed immediate emergency medical attention. I.G. Ex. 7, at 4. A medical team arrived shortly thereafter but AP was in full cardiopulmonary arrest. I.G. Ex. 7, at 8. The team was unable to resuscitate AP. He expired at 10:02 p.m. on December 29, 2001. I.G. Ex. 7, at 11.

The evidence offered by the I.G. is prima facie proof that Respondent failed to discharge its duty to provide AP with the screening examination that is required by EMTALA to identify the cause of his complaints and problems. AP failed to receive an examination despite an obvious, progressive deterioration in his condition over a period of about three hours and despite the many pleas by his family that Respondent's staff attend to AP's problems.

Respondent acknowledges that its failure to provide AP with a screening examination during the nearly three hours he waited at Respondent's emergency room may have comprised a negligent failure by its staff to attend to and treat AP. Respondent avers that its failure to respond promptly to AP was triggered by a single event, the triage that classified AP's condition to be "routine." Arguably, according to Respondent, that classification was a negligent diagnosis of AP's condition. But, it contends that its negligence – if it was negligent – cannot be construed to be a violation of EMTALA. Respondent's closing brief at 1.

Respondent asserts that EMTALA is not a federal malpractice statute that makes hospitals liable for all negligence that is committed in their emergency rooms. It contends that negligent performance of triage is simply not an action that is within EMTALA's purview. Moreover, according to Respondent, it should not be held to have violated EMTALA because there is no evidence in this case that it intended to withhold a screening examination from AP. Although it may have negligently delayed in providing such an examination, such delay was in the innocent context of the arguably negligent classification made by its triage nurse and not a willful or deliberate withholding of care. Respondent argues that, had its triage nurse assessed AP's condition as being more serious than routine, AP certainly would have received a screening examination timely. It asserts that to hold it liable for failing to provide AP with a screening examination would be to construe EMTALA as a strict liability statute because Respondent "did not perform actions it otherwise would have performed but for the negligent classification of [AP] by the nurse." Respondent's closing brief at 4. Respondent argues that there is no language in EMTALA which imposes such an obligation on it.

I am not persuaded by Respondent's argument. To begin with, it is incorrect to characterize what happened to AP as stemming solely from an arguably incorrect triage assessment. The evidence supports a conclusion that Respondent's staff grossly neglected AP's needs. That neglect was not limited to triage. The evidence proves that Respondent's staff was indifferent to AP and his problems – for about three hours – despite being told repeatedly that AP was manifesting signs that any reasonable medical professional should have construed potentially to be life-threatening. Certainly, the triage assessment may have been a contributing factor to the staff's failure to attend to AP. But, it is evident that Respondent's staff ignored AP and his family's pleas for help despite being told repeatedly that his condition was deteriorating. The staff failed to provide AP with a screening examination even after being told that AP was having difficulty breathing.

EMTALA does not excuse a hospital for failing to perform a screening examination where that failure is the consequence of the hospital's staff's gross negligence. EMTALA is unequivocal. A hospital *must* provide a screening examination to every individual who comes to its emergency department requesting treatment. There is no "negligence" exception to the law. Respondent's failure to provide AP with a screening examination comprises a violation of EMTALA.

Respondent relies on several United States Court of Appeals decisions which, it contends, support its assertion that a negligent diagnosis is never a violation of EMTALA. Principally, Respondent relies on the Ninth Circuit decision in *Jackson v. East Bay Hosp.*, 246 F.3d 1248 (9th Cir. 2001). But neither *Jackson* nor any of the other circuit court decisions relied on by Respondent support its contention that a negligent failure to

provide a screening examination is exempt from EMTALA liability. Indeed, close reading of these decisions supports my conclusion that negligent failure to provide a screening examination is an EMTALA violation.

In *Jackson,* the Ninth Circuit defined the issue that it resolved as being:

> whether a hospital violates . . . [EMTALA] if it fails to diagnose the cause of a patient's emergency condition, but treats the symptoms identified, and concludes that the patient has been stabilized.

246 F.3d at 1251-52.

The patient in *Jackson* was an individual who presented at a hospital's emergency room on several occasions complaining of a variety of symptoms. On each occasion he was seen first by a triage nurse and then, subsequently, examined by a physician. The medical staff who examined the patient determined that he was suffering from symptoms related to a psychiatric disorder and they ordered care that was commensurate with their diagnosis. The staff failed to identify the patient's toxic reaction to an anti-psychotic medication and that reaction ultimately led to the patient's death.

The Ninth Circuit held that the hospital was not liable for violating EMTALA. It concluded that a hospital satisfies EMTALA's "appropriate medical screening" requirement if it provides a patient with an examination comparable to that which is offered to other patients presenting similar symptoms, "unless the examination is so cursory that it is not designed to identify acute and severe symptoms" that alert the examining physician to the need for immediate medical intervention. *Jackson*, 246 F.3d at 1256.

The issue in *Jackson* is very different from that which is presented in this case and the Ninth Circuit's analysis is simply inapplicable to the present facts. *Jackson* addressed the question of whether an arguably negligently performed screening examination is a violation of EMTALA. The court concluded that it was not. What distinguishes this case from *Jackson* is that AP never received a screening examination.

Other cases relied on by Respondent are distinguishable on the same basis. For example, in *Baker v. Adventist Health, Inc. et al.*, 260 F.3d 987 (9th Cir. 2001), the Ninth Circuit held that a hospital was not liable for an EMTALA violation for having an outside practitioner assist in providing a psychiatric assessment of a patient as part of a screening examination. The court in *Baker* held that EMTALA does not require a hospital to rely solely on in-house personnel to perform a screening examination, noting that the screening examination requirement of EMTALA is limited to imposing on a hospital the

duty to perform an examination that is within the hospital's capability. Thus, under EMTALA, a hospital may rely on outside assistance to provide screening that is beyond the hospital's own capability and, under that circumstance, it is not liable under EMTALA for arguable negligence in the performance of such an examination by an outside provider.

But, in *Baker*, as with *Jackson*, a screening examination was performed. *Baker,* therefore, has no bearing on a case such as this one where there was no screening examination.

Similarly, in *Marshall v. East Carroll Parish*, 134 F.3d 319 (5th Cir. 1998), the United States Court of Appeals for the Fifth Circuit held that under EMTALA an "appropriate medical screening examination" is not judged by its proficiency in accurately diagnosing a patient's illness. Rather, the standard is whether the patient received an examination that is comparable to that which is provided to other patients who suffer from the same symptoms. *Marshall* involved a fifteen-year-old patient who received an arguably inadequate screening that resulted in a misdiagnosis. She was unable to communicate verbally, but the physician diagnosed her with a respiratory infection and discharged her. It was later discovered that she was suffering from a cerebrovascular accident. 134 F.3d 321. The court sustained a finding of summary judgment for the defendant hospital, holding that the screening examination given in that case was comparable to that which the hospital gave to all of its patients. 134 F.3d 323. As with the other decisions relied on by Respondent, *Marshall* is distinguishable from the present case. In *Marshall* what was put at issue was the quality of a screening examination. That issue is not before me because, in this case, no screening examination was ever provided to AP.

Respondent also cites *Correa v. Hosp. San Francisco*, 69 F.3d 1184, 1192-93 (1st Cir. 1995) to support the proposition that a faulty or negligent screening examination does not contravene EMTALA. But, in fact, in *Correa*, the defendant hospital was found to have violated EMTALA by failing to provide a screening examination to a patient. Indeed, the facts of *Correa* are essentially on all fours with those of this case and actually support my analysis of Respondent's EMTALA violation.

In *Correa*, the patient arrived at the hospital emergency room complaining of dizziness, nausea, and chest pain. She sat in the emergency room for more than two hours waiting to be examined and finally, and in desperation, left the hospital to seek treatment elsewhere. The First Circuit upheld a jury finding that the hospital's negligent delay in providing the patient with a screening examination was tantamount to a failure to perform the examination.

Correa highlights the distinction between a faulty screening examination which, with some exceptions, is not a basis for finding an EMTALA violation, and the failure to provide one, which is an EMTALA violation in *every* case. *Correa* is an example of the latter circumstance. Another example which highlights this distinction is *Scruggs v. Danville Reg'l Med. Ctr. Of Va.*, No. 4:08CV00005, 2008 WL 4168645 (W.D. Va. Sept. 5, 2008). *Scruggs* involved a patient who presented at an emergency room complaining of symptoms including prolonged dry heaves over the previous two days. The triage nurse determined the patient's status to be "non-urgent" and, as a consequence, the patient waited about eleven and one-half hours before being given a screening examination. Shortly thereafter, the patient became unresponsive and went into cardiac arrest.

The court in *Scruggs* held that these facts were sufficient to justify a trial on the issue of whether the hospital violated EMTALA by delaying unreasonably the performance of a screening examination. The court acknowledged that EMTALA does not guarantee a patient that a screening examination will produce a correct diagnosis of the patient's medical condition. It agreed with the decisions in *Jackson* and in similar cases that EMTALA is not a medical malpractice statute and that, consequently, negligent performance of a screening examination is not necessarily a cause of action under EMTALA.[2] The court held, however, that EMTALA imposes an absolute duty on a hospital to perform a screening examination. Triage is not a screening examination, nor is negligently conducted triage an excuse for failing to perform a screening examination. Consequently, the plaintiff had a viable cause of action to challenge the delay in performing a screening examination even if that delay was caused by negligently conducted triage.

Finally, Respondent argues that there exists no basis to find an EMTALA violation in this case because the I.G. failed to prove that Respondent treated AP differently from other patients in its emergency room. It asserts that there can be no EMTALA violation in the absence of evidence that it applied screening criteria to AP that differed from those applied to other, similar patients.

I find this argument to be without merit. None of the cases relied on by Respondent, including *Jackson*, suggests that a hospital may avoid liability for an EMTALA violation by claiming that it treated all of its emergency room patients equally poorly. The court in *Jackson* held that a hospital cannot avoid the requirements of EMTALA by giving all of

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[2] The district court in the *Scruggs* case is located in a State which is within the jurisdiction of the Fourth Circuit United States Court of Appeals. The Fourth Circuit follows the same rule as is stated in *Jackson*. *Baber v. Hosp. Corp. Of Am.*, 977 F.2d 872 (4th Cir. 1992).

its patients examinations that are so cursory as to make it unlikely that significant medical conditions will be diagnosed. But, more important, Respondent's argument sidesteps the fact that this case is not about the performance of an inadequate screening examination. Here, *no* screening examination was performed. It is Respondent's failure to provide a screening examination that is the reason for its EMTALA liability and not the quality of the care that it provided.

2. A civil money penalty of $50,000 is reasonable.

A participating hospital that violates EMTALA may be subject to a civil money penalty of not more than $50,000 for each violation. Act, section 1867(d)(1)(A). The Secretary of Health and Human Services has published regulations which establish the criteria for determining the amount of a civil money penalty to be imposed for an EMTALA violation. 42 C.F.R. §§ 1003.102(c)(1); 1003.106(a)(4)(i)-(vi); 1003.106(d)(1)-(5). The regulations require consideration of the following factors:

- The degree of the Respondent's culpability;
- The seriousness of the condition of the person seeking emergency medical treatment;
- Any other instances where the Respondent failed to provide care consistent with the requirements of EMTALA;
- The 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)(i)-(vi). The regulations also describe when evidence relating to these factors should be considered as aggravating or mitigating. 42 C.F.R. § 1003.106 (d)(1)-(5). Evidence must be construed to be aggravating where an individual presents himself or herself to an emergency room with a condition that meets the definition of a medical emergency.[3]

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[3] A medical emergency is defined at 42 C.F.R. § 489.24 to include a condition manifesting itself with symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to: place the individual's health in jeopardy; cause serious impairment to bodily functions; or cause serious dysfunction of any body organ. From the first moment that AP presented himself at

I have considered the evidence as it relates to these regulatory criteria. Respondent has not offered evidence about its financial condition. Nor is there evidence showing any prior history of EMTALA violations by Respondent. There is relevant evidence addressing three of the regulatory factors: Respondent's level of culpability for its EMTALA violation; the nature and circumstances of Respondent's violation; and, the condition of AP at the time that he sought medical treatment. I find that such evidence strongly supports a maximum civil money penalty of $50,000 even though there is no evidence that Respondent committed previous EMTALA violations.

The failure to provide AP with a screening examination was shocking in light of the facts that were known to Respondent's staff on the evening of AP's death. It should have been obvious from the moment that AP presented himself at the emergency room that his condition was grave and that he merited immediate and urgent attention by Respondent's staff.[4] Furthermore, the events that transpired on the evening of December 29, 2001 prove that Respondent's staff botched horribly the care that they gave to AP. This was not simply a case of a poorly performed triage as is asserted by Respondent. To the contrary, the record of this case shows that the triage – which was by any measure inadequate – was merely one of a constellation of massive failures by Respondent's staff to attend to and help AP. It is fair to characterize Respondent's treatment of AP as constituting a complete collapse of the system of care that it purported to offer emergency patients. The evidence shows that, first, AP had to wait for more than an hour – despite his complaints of extremely grave symptoms – to receive even cursory triage. Moreover, over a period of about three hours, AP's family repeatedly pled with Respondent's staff to attend to AP as his condition deteriorated. Their pleas fell on deaf ears. The insensitivity of Respondent's staff to AP's condition continued even after AP was finally received into the examining and treatment part of Respondent's emergency room because even there, he was denied the most basic care (oxygen and cardiac monitoring) that had been ordered for him.

This evidence proves that Respondent manifests a high level of culpability for its neglect of AP. But, there is more, and this additional evidence underscores both Respondent's culpability and the seriousness of its EMTALA violation. The evidence establishes that the person performing triage at Respondent's emergency room on the evening of

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Respondent's emergency room his condition clearly satisfied this definition. I.G. Ex. 18, at 4.

[4] It is astonishing that the nurse who performed the triage failed to react to the fact that AP's tongue was so swollen that he could not speak. That sign in and of itself should have signaled to the triage nurse that AP manifested a life-threatening condition which could be interfering with his ability to breathe. I.G. Ex. 18, at 4.

December 29, 2001 was not qualified – under Respondent's own criteria – to perform triage. Respondent's policy required persons performing triage to have six months of emergency room experience and receive formal triage training before performing triage assessments independently. I.G. Ex. 14, at 6. But, in this instance, the triage nurse – who independently assessed AP – had neither the requisite experience nor the required formal training. *Id.*

I find no mitigating evidence to be present in this case. This may have been the first instance of an EMTALA violation by Respondent. But, if so, it is so egregious as to merit a maximum civil money penalty in and of itself.

/s/
Steven T. Kessel
Administrative Law Judge