DEPARTMENT OF HEALTH AND HUMAN SERVICES

Departmental Appeals Board

Civil Remedies Division

In the Case of:	
The Inspector General	DATE: JUL 28, 1989
- v. -	Docket No. C-42
Michael L. Burditt, M.D.,	DECISION CR 35
Respondent.	

DECISION AND ORDER

This is the first case tried under a new federal law enacted to provide equal access to health care in hospitals with emergency departments and to prevent inappropriate transfers of individuals from one hospital to another. Section 1867 of the Social Security Act (Act) requires all participating hospitals in the United States and their "responsible physicians" to provide a screening examination to any individual, regardless of ability to pay, who comes into the emergency department. The purpose of the screening examination is to determine if that individual has an "emergency medical condition" or is in "active labor." Section 1867 also requires all such hospitals and their "responsible physicians" to provide further examination and necessary treatment to "stabilize" any individual with an "emergency medical condition" and to provide treatment to any woman in "active labor;" a transfer of any such individual can be made only under certain very restrictive circumstances and only if the medical benefits outweigh the risks from the transfer. Inappropriate transfers and other violations of Section 1867 may subject hospitals and "responsible physicians" to a civil monetary penalty.

In this case, the Inspector General (I.G.) of the United States Department of Health and Human Services (DHHS) seeks a civil monetary penalty in the amount of twenty five thousand dollars ($25,000) from Michael L. Burditt, M.D. (Respondent). The I.G. alleges that Dr. Burditt knowingly violated Section 1867 of the Act by

transferring Mrs. Rosa Rivera from DeTar Hospital in Victoria, Texas on December 5, 1986. More specifically, the I.G. alleges that Mrs. Rivera had an "emergency medical condition" that had not been stabilized; that she was in "active labor" at a time when the medical benefits of transfer clearly did not outweigh the medical risks associated with the transfer; that Dr. Burditt failed to treat the "active labor" or the "emergency medical condition;" that Respondent falsely certified that the benefits outweighed the risks of transfer; and that Respondent failed to ensure that the transfer was effected through qualified personnel and transportation equipment, including necessary and medically appropriate life support measures.

Dr. Burditt argues that he is not a "responsible physician" under Section 1867 of the Act and that the I.G. failed to prove the allegations against him. Dr. Burditt argues in the alternative, assuming a technical violation did occur, that any civil monetary penalty imposed should not exceed one hundred dollars ($100.00) because of the presence of mitigating circumstances and the absence of aggravating circumstances.

A trial-type hearing was held before this United States Administrative Law Judge (ALJ) beginning on Tuesday, January 24, 1989 and concluding on Friday, January 28, 1989. Eleven witnesses testified at the hearing, and the parties submitted exhibits in support of their positions. The parties were represented by competent and well-prepared attorneys.[1] Post-hearing written arguments and proposed findings of fact and conclusions of law were submitted. Based on my study of the evidence in the record, the arguments, and after due consideration of the facts and law, I find and conclude that Dr. Burditt did knowingly violate requirements of Section 1867 of the Act by transferring Mrs. Rosa Rivera from DeTar Hospital on December 5, 1986. I conclude, after weighing all mitigating and aggravating circumstances, that Respondent should pay a civil monetary penalty of twenty thousand dollars ($20,000).

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[1] Respondent was represented by Edward J. Ganem of Victoria; Hugh M. Barton, C. J. Francisco, III, and Donald P. "Rocky" Wilcox of the Texas Medical Association in Austin, Texas; and William De Witt Alsup of Corpus Christi, Texas. The Inspector General was represented by Linda Grabel, John Meyer, and Leslie Shaw, of Washington, D.C.

APPLICABLE STATUTES AND REGULATIONS

I. Statutes.

This case is governed by Section 1867 of the Social Security Act, codified at 42 U.S.C. 1395dd.[2] On December 5, 1986, Section 1867 provided for a civil money penalty of up to $25,000 for each violation of any requirement of Section 1867.[3] [4]

II. Regulations.

The governing federal regulations (Regulations) are codified in 42 C.F.R. 1003.100 through 1003.133 (1987) and 52 Fed. Reg. 49412 (December 31, 1987). These Regulations provide for a full and fair trial-type hearing before an ALJ.

BACKGROUND

On April 26, 1988, the I.G., through Eileen T. Boyd, Deputy Assistant Inspector General, Civil Fraud Division, sent a notice of proposed determination (Notice) to

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[2] Section 1867 of the Act is entitled "Examination and Treatment for Emergency Medical Condition and Women in Active Labor" and was added by section 9121 of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, Pub. L. No. 99-272, 100 Stat. 164 (effective August 1, 1986).

[3] Presently, Section 1867 provides for a civil monetary penalty of up to $50,000 for each such violation occurring after July 1, 1988. Also, if a hospital knowingly and willfully, or negligently violates any requirement of section 1867, the hospital can be terminated or suspended from the Medicare and Medicaid programs.

[4] This federal law has been referred to by the public and by Congress as the federal anti-dumping or patient dumping act. See, e.g., H.R. Rep. No. 100-531, 100th Cong., 2d Sess. (March 25, 1988). Some people, including many in the medical community, object to this characterization (dumping) of what in some instances may be a mistaken (although law-violating) judgment by an otherwise respected health care professional. Dr. Warren Crosby, a highly respected physician and professor of medicine who testified for the I.G. as an expert witness, is one of those who finds the term "dumping" to be offensive.

Dr. Burditt, a board-certified medical doctor practicing obstetrics and gynecology in Victoria, Texas. The Notice informed him that the I.G. had determined that on December 5, 1986 he had violated requirements of Section 1867 of the Act, and should pay a civil monetary penalty of $25,000 for those violations. On May 2, 1988, Respondent contested the I.G.'s determination and requested a hearing before an ALJ. On September 16, 1988, the I.G. issued an Amended Notice, alleging that the transfer of Mrs. Rivera was not effected through qualified personnel and transportation equipment; Respondent also contested the allegations in the Amended Notice.

A prehearing conference was held in Victoria, Texas on August 31, 1988, and several prehearing rulings were issued by me prior to the January 1989 hearing.

SUMMARY OF PREHEARING RULINGS AND ORDERS

I hereby reaffirm all Prehearing Rulings and Orders.

I. Preparation For The Hearing.

A Prehearing Order and Notice of Hearing was issued by me on September 12, 1988 setting forth a schedule for the parties to prepare for the hearing. I issued Amendments on December 2, 1988, requiring the parties to submit the direct testimony of all proposed expert witnesses in writing.

On December 2, 1988, I issued a Ruling denying the I.G.'s motion to exclude certain witnesses. On December 23, 1988, I ordered the I.G. to produce certain documents sought in discovery by Respondent, for the reasons stated in my December 16, 1988 Ruling concerning production of documents.

II. The Applicable Burden of Proof, Standard Of Liability, And Regulations.

On December 22, 1988, I determined the law applicable to this case to be as follows: (1) the procedural provisions of the federal regulations at 42 C.F.R. Part 1003 apply to this case to the extent that they are consistent with Section 1867 of the Act; (2) the I.G. has the burden of proving his allegations of liability and aggravating circumstances, and Respondent must prove mitigating circumstances, by a preponderance of the evidence; and (3) the "knowingly" standard of liability in Section 1867 requires proof of actual knowledge, reckless disregard,

or deliberate ignorance; the term "knowingly" does not encompass "reason to know" or simple mistakes. [5] [6] [7]

III. Ruling Denying Respondent's Motion To Dismiss And The I.G.'s Motion For Summary Judgement.

A. Responsible Physician.

Section 1867 of the Act provides that a civil monetary penalty may be imposed against a "responsible physician" who is "employed by" or "under contract with" a participating hospital.

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[5] Although there is a proposed rule (NPRM) dated June 16, 1988, DHHS has yet to promulgate final federal regulations for Section 1867 cases. I conclude that the procedural aspects of the federal regulations set forth in 42 C.F.R. Part 1003 (Regulations) apply to this case because Congress intended them to apply and because Respondent was given timely notice that the I.G. intended to proceed under these Regulations. The Regulations have provisions that include the due process rights of notice, opportunity to be heard, the right to cross examine witnesses, and appeal from an ALJ's decision and order.

[6] Respondent argued that the proposed penalty is "criminal in nature" and that, accordingly, the burden of proof should be "beyond a reasonable doubt". Cf. United States v Halper, ____ U.S. ____ (No. 86-1383, May 15, 1989).

[7] I conclude that when Congress uses the term "knowingly," as it does in Section 1867, it means to include actual knowledge, reckless disregard, and deliberate ignorance, because Congress defines "knowingly" to include these terms in the Civil False Claims Act (31 U.S.C. 3729) as follows:

(b) KNOWING AND KNOWINGLY DEFINED -- For the purposes of this section, the terms "knowing" and "knowingly" mean that a person, with respect to information --

(1) has actual knowledge of the information;
(2) acts in deliberate ignorance of the truth or falsity of the information; or
(3) acts in reckless disregard of the truth or falsity of the information, and no proof of specific intent to defraud is required.

On December 22, 1988, I concluded that, as a matter of federal law, if a staff physician acts to fulfill a hospital's duty to provide emergency services to the community as a condition of maintaining the physician's privileges at a hospital, the physician is "under contract with" that hospital for the purposes of Section 1867 of the Act.

B. Adequate Notice.

I also ruled that the I.G., in his April 26, 1988, and September 16, 1988 Amended Notice, met the due process notice requirements set forth in the regulations at 42 C.F.R. Section 1003.109 and in Section 554(b) of the Administrative Procedure Act (APA).[8]

ISSUES

The principal issues are set forth below.

A. Liability.

1. Whether the I.G. proved that, on December 5, 1986, Dr. Burditt knowingly violated any requirements of Section 1867 of the Act:

> a. whether the I.G. proved that Dr. Burditt transferred Mrs. Rosa Rivera while she had an "emergency medical condition" that was not stabilized;
>
> b. whether the I.G. proved that Dr. Burditt transferred Mrs. Rosa Rivera while she was in "active labor;"
>
> c. whether the I.G. proved that Dr. Burditt falsely certified that the benefits of transfer outweighed

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[8] The I.G. asserted in his Notice that Dr. Burditt violated Section 1867 and alleged that the Respondent transferred Ms. Rivera, who had both an "emergency medical condition" and who was in "active labor." I concluded in this Ruling on December 22, 1988 that the fact that the I.G. did not specify which of the three definitions found in Section 1867 (of the terms "emergency medical condition" and "active labor") applied to Ms. Rivera did not prevent Dr. Burditt from preparing a defense. I conclude that the I.G.'s pleading in the alternative did not deprive Respondent of his right to adequate notice or to a fair hearing.

the risks (i.e., whether Dr. Burditt should have stabilized Mrs. Rivera's "emergency medical condition" and treated her "active labor" prior to transfer);

d. whether the I.G. proved that Dr. Burditt transferred Mrs. Rosa Rivera "without qualified personnel and transportation equipment."

2. Whether the I.G. proved that, on December 5, 1986, Dr. Burditt was a "responsible physician," as defined by Section 1867 of the Act.

B. The Amount Of The Civil Monetary Penalty.

3. Whether the I.G. proved the aggravating circumstances alleged.

4. Whether Respondent proved the mitigating circumstances alleged.

5. Whether the amount of the proposed civil monetary penalty is appropriate under the circumstances of this case.

FINDINGS OF FACT AND CONCLUSIONS OF LAW [9] [10] [11]

1. Michael L. Burditt (Respondent) is a medical doctor and has practiced obstetrics and gynecology (OB/GYN) in Victoria, Texas since 1974. Tr 805.

2. Dr. Burditt applied for appointment to the active medical staff of DeTar Hospital in Victoria, Texas in 1974, became board certified in OB/GYN in 1976, and was Chief of the OB/GYN Department at DeTar Hospital on December 5, 1986. J Ex 6/1, 5; Tr 803; Stip B4.

3. On December 5, 1986, DeTar Hospital was a Medicare participating hospital, within the meaning of 42 U.S.C. 1395dd and was the only hospital in Victoria, Texas with a labor and delivery department. R Ex A/2.

4. Experiencing symptoms of ruptured membranes and severe hypertension, Mrs. Rosa Rivera, an indigent unaligned individual pregnant with her sixth child, arrived at DeTar Hospital's emergency room on December 5, 1986, at approximately 4:00 p.m., requesting treatment and examination. An unaligned patient is one who does

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[9] The citations to the record in this Decision and Order are noted as follows:

Oct. 18, 1988 Agreed Stipulation of Facts	Stip (number)
Hearing Transcript	Tr (page)
Joint Exhibits	J Ex(number)/(page)
I.G.'s Exhibits	I.G. Ex(number)/(page)
Respondent's Exhibits	R Ex(number)/(page)
Respondent's Posthearing Brief	R Br(page)
Respondent's Reply Brief	R Rep Br(page)
I.G.' Posthearing Brief	I.G. Br(page)
I.G.'s Reply Brief	I.G. Rep Br(page)
Findings of Fact and and Conclusions of Law	FFCL(number)

[10] Some of the proposed findings and conclusions offered were rejected because they were not supported by the evidence, needed to be modified, or were not material.

[11] Any part of this Decision and Order preceding the Findings of Fact and Conclusions of Law which is obviously a finding of fact or conclusion of law is incorporated herein.

not have a physician. Stip B5, B6, B7; J Ex 1/7; I.G. Ex 2/2; Tr 84.

5. DeTar Hospital was required by federal law to provide for an appropriate medical screening examination of Mrs. Rivera in order to determine whether an "emergency medical condition" existed and to determine whether she was in "active labor." 42 U.S.C. 1395dd(a).

6. DeTar Hospital fulfilled its duty under federal law to provide for the initial screening of Mrs. Rivera.

7. If DeTar Hospital determined that Mrs. Rivera had an "emergency medical condition," DeTar Hospital was required by Section 1867 of the Act to affirmatively either:

a. provide for such further medical examination and treatment required to stabilize Mrs. Rivera's medical condition; or

b. provide for her transfer to another medical facility in accordance with the requirements in Section 1867 of the Act.

8. There is no dispute that Mrs. Rosa Rivera had an "emergency medical condition" on December 5, 1986.

9. If DeTar Hospital determined that Mrs. Rivera was in "active labor," DeTar was under an affirmative duty to either:

a. provide for further examination and treatment of her labor; or

b. provide for her transfer to another medical facility in accordance with the requirements in Section 1867 of the Act.

10. Mrs. Rivera was in "active labor" on December 5, 1986 (see FFCL 100-113, infra).

11. On December 5, 1986, DeTar Hospital had delegated to Dr. Burditt its duty to examine, determine Mrs. Rivera's condition, and treat Mrs. Rivera.

12. Dr. Burditt was the "responsible physician," who was designated to act on behalf of DeTar Hospital with respect to the examination, treatment, and care of Mrs. Rivera.

13. The I.G. proved by a preponderance of the evidence that, on December 5, 1986, DeTar Hospital knowingly violated requirements of Section 1867 of the Social Security Act.

14. DeTar Hospital has already been sanctioned for its violations of requirements of Section 1867.

15. Dr. Burditt was the "responsible physician" with respect to DeTar Hospital's violations of requirements of Section 1867 of the Act.

16. The I.G. proved by a preponderance of the evidence that on December 5, 1986, Dr. Burditt was a "responsible physician" as defined by Section 1867 of the Act. See 42 U.S.C. 1395 x(r).

17. The I.G. proved by a preponderance of the evidence that, on December 5, 1986, Respondent knowingly violated requirements of Section 1867 of the Act.

18. As a member of the active staff of DeTar Hospital, Dr. Burditt agreed to abide by the hospital's by-laws, rules, standards, policies, and regulations. J Ex 6/22.

19. As a member of the staff of DeTar Hospital, all OB/GYN physicians are required to do an emergency rotation for unaligned patients. Tr 84.

20. As a member of the staff, Dr. Burditt had agreed to provide emergency medical care to unaligned patients at DeTar Hospital and the hospital, in turn, allowed him to admit his own patients and to use the hospital's personnel and resources to treat them. J Ex 6/22; J Ex 8/15; I.G. Ex 5/2.

21. As a member of the staff, Dr. Burditt had agreed to provide emergency medical care to unaligned patients on a rotating basis, and was under contract to do so. J Ex 7/4, R Ex 2/2; J Ex 8/18; Tr 84.

22. On December 5, 1986, Dr. Burditt was on the unaligned patient call list for the OG/GYN Department of DeTar Hospital and was substituting for two other physicians. Tr 84, 85, 329, 814, 815; Stip B10; I.G. Ex 1/1; I.G. Ex 2/2.

23. Mrs. Rivera was initially examined by Tammy Kotzur, a labor and delivery unit nurse. J Ex 1/7, 12; Tr 123.

24. Upon examination by Nurse Kotzur, Mrs. Rivera was found to have the following conditions:

a. gravida six para five (a pregnant woman in her sixth pregnancy, with five previous births);
b. a blood pressure of 210/130;
c. moderate contractions every three minutes, lasting 60 seconds (contractions started at 7 a.m.);
d. a positive nitrazine test (indicating leaking or ruptured membranes);
e. a dilated cervix three centimeters and 60-70% effaced;
f. she reported having had spontaneous rupture of membranes at 3:15 p.m.;
g. she gave the date of her last menstrual period as March 13, 1986 (if she went full term, her estimated date of delivery was December 14, 1986);
h. the baby's head was ballottable;
i. she was at or near term. Stip B8; J Ex 1/2, 4, 6-8.

25. Nurse Donna Kiening, the supervisor of the labor and delivery department at DeTar Hospital, was asked by Nurse Kotzur to verify Mrs. Rivera's blood pressure reading because it was so high. Tr 122, 123.

26. At the time Mrs. Rivera first arrived at DeTar Hospital on December 5, 1986, Dr. Burditt was the physician designated on the Hospital's unaligned patient call list to take the next such patient. Stip B10.

27. Between 4:00 p.m. and 4:15 p.m., on December 5, 1986, Nurse Kotzur called Dr. Burditt and informed him of Mrs. Rivera's condition. Stip B11; J Ex 1/7; I.G. Ex 1/1; I.G. Ex 2/2; Tr 85, 123, 814, 881.

28. Nurse Kotzur advised Dr. Burditt that Mrs. Rivera's blood pressure was 210/130; her cervix was three centimeters dilated and 70% effaced with the head ballottable. Her contractions had started that morning, her membranes had ruptured, and her estimated full-term due date was mid-December. J Ex 1/7, 12.

29. When advised of these conditions, Dr. Burditt stated over the phone that "he did not want to take care of this lady" (I.G. Ex 1/1) and told Nurse Kotzur that the patient should be transferred to John Sealy Hospital, approximately 160 to 170 miles from DeTar Hospital. Stip B12; Tr 124; I.G. Ex 1/1.

30. When Dr. Burditt told Nurse Kotzur that the patient should be transferred, Nurse Kotzur asked if it was because of Mrs. Rivera's blood pressure, to which Dr. Burditt responded: "yes." I.G. Ex 1/1.

31. Concerned by Dr. Burditt's reaction to transfer Mrs. Rivera, Nurse Kotzur requested that Dr. Burditt call back in five to ten minutes. I.G. Ex 1/1; Tr 124.

32. Nurse Kotzur told her supervisor, Nurse Kiening that Dr. Burditt wanted to transfer Mrs. Rivera, and both nurses considered the transfer to be unsafe. Tr 123, 124 145, 146, 148; I.G. Ex 2/2.

33. At 4:15 p.m., an entry was made in Mrs. Rivera's medical record under "physician's orders" which stated: "prepare pt for transfer to John Sealy Hospital in Galveston." This order was later countersigned by Dr. Burditt. J Ex 1/4.

34. DeTar Hospital's rules and regulations provide that if a nurse has reason to doubt or question the care of a patient, she should call it to the attention of her superior, who in turn is directed to call the Director of Nursing Services. The Director of Nursing Services is directed to call the attending physician, the administrator, or the chief of staff. J Ex 7/9.

35. Jean Herman, Associate Director of Nursing, was Nurse Kiening's supervisor and was the "house supervisor" on December 5, 1986. It was the policy of DeTar Hospital that the house supervisor be involved in any transfer of a patient. Tr 85, 101, 124.

36. At 4:25 p.m. on December 5, 1986, Nurse Kiening called Nurse Herman to inform her of the possible transfer of Mrs. Rivera and of the nurses' feeling that transfer would be "unsafe." I.G. Ex 2/2; Tr 83, 85, 124, 145.

37. Nurse Herman told Nurse Kiening to call Charles Sexton, who had been the Administrator of DeTar Hospital since 1981. Tr 86, 101, 125; I.G. Ex 5/1.

38. Between 4:25 p.m. and 4:30 p.m., Nurse Kiening telephoned Mr. Sexton to advise him of the possible transfer of Mrs. Rivera and the nurses' feelings that the transfer was unsafe. I.G. Ex 2/2; Tr 125, 145, 154, 156.

39. Nurse Herman took a copy of the new COBRA law and a copy of the hospital's guidelines to Mr. Sexton to verify that these materials needed to be followed. Tr 85, 101.

40. Mr. Sexton told Nurse Herman that she needed to have Dr. Burditt sign the "Physician's Certificate Authorizing Transfer." Tr 114.

41. Hospital guidelines provide that, prior to a transfer, the transferring physician must personally examine and evaluate the patient to determine the patient's medical needs. J Ex 3/2, 3. Section 1867 also requires this.

42. At approximately 4:20 p.m., Dr. Burditt telephoned the hospital from his automobile and was directed to speak to Nurse Kiening. During the conversation between Dr. Burditt and Nurse Kiening, she advised him that the nurses felt the transfer was unsafe. I.G. Ex 1/1; I.G. Ex 2/2; Tr 126, 145, 152, 819, 885.

43. Nurse Kiening told Dr. Burditt that he would have to telephone John Sealy Hospital himself and that he would have to perform an in-person evaluation of the patient if he wanted her to be transferred. I.G. Ex 1/1.

44. Nurse Kiening asked Dr. Burditt if she could start an IV (intravenous) or give magnesium sulfate. Dr. Burditt told Nurse Kiening that she could start an IV if Mrs. Rivera could be transported by emergency medical services (E.M.S.), but that if Mrs. Rivera could not be transported by E.M.S., Nurse Kiening was not to start an IV. I.G. Ex 1/1; I.G. Ex 2/2; Tr 126, 165.

45. A phone order was placed in the "physician's orders" of Mrs. Rivera's medical records at 4:30 p.m. to start an IV. Contrary to Dr. Burditt's orders, Nurse Kiening started an IV on Mrs. Rivera at approximately 4:40 p.m. on December 5, 1986. She stated that she started the IV as a safety measure, since Mrs. Rivera's blood pressure was so high, in case there were complications. J Ex 1/4; J Ex 1/8; I.G. Ex 2/2; Tr 127, 157.

46. Dr. Burditt arrived at the hospital at approximately 4:50 p.m. Upon arrival, Dr. Burditt requested that Nurse Kiening start the transfer proceedings while he examined the patient. I.G. Ex 1/2; I.G. Ex 2/2; Tr 158.

47. Dr. Burditt examined Mrs. Rivera between 4:50 p.m. and 5:00 p.m. J Ex 1/8.

48. Between 4:50 p.m. and 5:00 p.m., Dr. Burditt called John Sealy Hospital and spoke to Dr. Downing, who agreed to accept Mrs. Rivera. Dr. Burditt told Dr. Downing that the patient should be there within three hours. During

this conversation, Dr. Downing requested that magnesium sulfate be administered. Stip B14; Stip B15.

49. The results of Dr. Burditt's assessment of Mrs. Rivera and his phone call to John Sealy Hospital were entered into the medical record at 5:00 p.m. Stip B16.

50. At approximately 5:00 p.m., Dr. Burditt informed Nurse Kiening that John Sealy Hospital had accepted Mrs. Rivera. Dr. Burditt gave orders to transfer Mrs. Rivera and asked Nurse Kiening to follow routine procedure for magnesium sulfate coverage. Stip B17; Tr 842.

51. Nurse Kiening started the magnesium sulfate IV push at 5:30 p.m., and it was completed at 6:00 p.m. An IV push is the administration of medicine intravenously by quick and forcible injection. J Ex 1/10, 11; I.G. Ex 3/5; Tr 132, 160.

52. The magnesium sulfate IV push was slower than prescribed, due to interruptions regarding the transfer. J Ex 1/10; J Ex 12/2; Tr 132, 133 166.

53. Magnesium sulfate (MgS04) is an anti-convulsant and the administration of magnesium sulfate was appropriate in this case. I.G. Ex 7/14; I.G. Ex 10/12; I.G. Ex 12/13, 27; Tr 238, 480, 719.

54. The magnesium sulfate protocol at DeTar Hospital provides for four grams IV push over five minutes and then five grams intramuscularly in each buttock. Three hours after the intramuscular dose, a continuous IV with IVAC is to be started. IVAC is the brand of a device which regulates the flow of the IV. J Ex 1/5.

55. At some time before 5:00 p.m., Nurse Herman came to the labor and delivery room to discuss Mrs. Rivera's transfer with Dr. Burditt. I.G. Ex 2/3; I.G. Ex 1/2; Tr 86, 129.

56. During their conversation, Nurse Herman stated to Dr. Burditt that there were certain standards to which the hospital needed to adhere. She showed him a copy of the hospital's guidelines that related to the COBRA LAW, but he declined to read the guidelines. Tr 87, 88, 103,104, 129-130.

57. Dr. Burditt told Nurse Herman that Mrs. Rivera was more high-risk than he was willing to accept from a malpractice standpoint. I.G. Ex 1/2.

58. On December 5, 1986, DeTar Hospital had a Level II perinatal unit. John Sealy Hospital had a Level III perinatal unit. J Ex 12/3; Tr 328, 448.

59. A Level III perinatal unit is usually necessary for babies with severe respiratory problems or babies severely premature. I.G. Ex 7/21; I.G. Ex 12/21.

60. Dr. Burditt accurately estimated Mrs. Rivera's baby at six pounds. Tr 825, 897; J Ex 1/6. A six pound baby, whether or not growth-retarded, could usually be cared for in a Level II facility. Tr 497.

61. Dr. Burditt told Nurse Herman that Mrs. Rivera was in early labor and that he thought Mrs. Rivera could make it to John Sealy Hospital in Galveston. I.G. Ex 1/2; Tr 87, 102, 115.

62. Dr. Burditt told Nurse Herman that until DeTar Hospital paid his malpractice insurance, he would pick and choose the patients he wanted to treat. I.G. Ex 2/3; Tr 30, 89, 129, 903, 905.

63. Dr. Burditt stated "give me that dang piece of paper" and signed a "Physician's Certificate Authorizing Transfer" of Mrs. Rivera. J Ex 1/13; Stip B18.

64. The transfer certificate signed by Dr. Burditt at approximately 5:00 p.m. states that he determined that "the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the patient's medical condition from effecting at transfer." Stip B19. However, he did not fill in the portion of the certificate which required him to list the benefits and risks. J Ex 1/13.

65. One of the risks of transferring Mrs. Rivera was that she might deliver before reaching John Sealy Hospital. I.G. Ex 7/20; I.G. Ex 10/19.

66. The growth-retarded fetus of a hypertensive mother is much more likely to suffer distress in labor since contractions further restrict the flow of oxygen. I.G. Ex 7/20-21.

67. Transfer significantly intensified the high risk to the fetus of death or disability due to fetal hypoxia or placental abruption. Fetal hypoxia is the deficiency of oxygen to the fetus. Placental abruption is the

premature separation of the placenta. I.G. Ex 7/22, 33; I.G. Ex 10/31; I.G. Ex 12/19, 20.

68. The risks of being born outside a hospital were much greater than the benefits a Level III facility would provide. I.G. Ex 7/35; I.G. Ex 10/20, 32; I.G. Ex 12/21.

69. Because of the distance from DeTar Hospital, no reasonable OB/GYN could have believed that the marginal benefits to be obtained at John Sealy Hospital outweighed the risks associated with the transfer of Mrs. Rivera. I.G. Ex 18-22; I.G. Ex 10/17-20.

70. Dr. Burditt acted in reckless disregard of the risks associated with the transfer of Mrs. Rivera when he signed the "Physician's Certificate Authorizing Transfer" in violation of Section 1867 of the Act. 42 U.S.C. 1395dd.

71. Subsequent to Dr. Burditt signing of the Physician's Certificate Authorizing Transfer, Nurse Kiening contacted E.M.S. to arrange for Mrs. Rivera's transfer. Tr 132, 156, 159; J Ex 5/4.

72. Nurse Herman attempted to locate a nurse to accompany Mrs. Rivera and called Nurse Anita Nichols. Nurse Nichols arrived at Detar Hospital at 5:45 p.m. and took over the care of Mrs. Rivera at 6:00 p.m. Tr 90, 91, 132; I.G. Ex 2/3; I.G. Ex 3/1, 2; J Ex 12/2.

73. Also, on December 5, 1986, Dr. Burditt was advised by Nurse Dawn Burns, in the labor and delivery department, that another unaligned patient, Sylvia Ramirez, had come in and that he must treat her. I.G. Ex 1/2; Tr 822.

74. After signing the transfer certificate for Mrs. Rivera, Dr. Burditt went to evaluate Mrs. Ramirez. I.G. Ex 1/2; Tr 836.

75. Mrs. Ramirez was bleeding heavily and later delivered at 6:22 p.m. on December 5, 1986. Tr 822; I.G. Ex 1/2.

76. When Dr. Burditt first arrived at DeTar Hospital on December 5, 1986, he knew that another physician was in the delivery room. Dr. Burditt later determined that it was Dr. Whitehouse. I.G. Ex 1/2; Tr 820-21, 846.

77. Dr. Ormazable is a board-certified neonatologist (specialist in the care of the newborn) on the staff of

DeTar Hospital and was in the hospital at approximately 6:25 p.m. on December 5, 1986. He was also present when Sylvia Ramirez's baby was delivered, and took over the care of Sylvia Ramirez's 3 1/2 pound baby. R Ex E/24, 30; Tr 87, 794.

78. DeTar Hospital's rules and regulations provide that any qualified practitioner with clinical privileges can be called upon for consultation. They also provide that the attending physician is primarily responsible for requesting a consultation, and such consultation is urged in unusually complicated situations. J Ex 7/8. The obstetricians and pediatricians at DeTar Hospital consider themselves to be a "close knit" group, but Dr. Burditt did not seek any consultation from physicians available at DeTar or on call. Tr 846, 891-92.

79. After Dr. Burditt's first and only examination of Mrs. Rivera, Dr. Burditt "inquired several times over the next hour and a half how the transfer of Mrs. Rivera was proceeding." Stip B20. However, he did not specifically inquire about her medical condition.

80. At 6:30 p.m., Dr. Burditt was shown the results of Mrs. Rivera's lab work, and inquired about Mrs. Rivera's cervical status. Dr. Burditt should have examined Mrs. Rivera and should have inquired about her blood pressure at this time. B21; Tr 133, 912, 916.

81. Nurse Nichols told Dr. Burditt that the results of her examination showed that Mrs. Rivera's cervix was three centimeters dilated, 70% effaced, and at minus two station. He then told Nurse Nichols that there had been no change in Mrs. Rivera's condition and to proceed with the transfer. Tr 841; J Ex 1/11.

82. Dr. Burditt did not give Nurse Nichols any further orders for medication during the transfer and did not order any life support or other measures for the ambulance. I.G. Ex 1/3; J Ex 1/4; Tr 134, 173.

83. The "Guidelines for Perinatal Care" indicate that a heart rate monitor (or fetal heart monitor) is essential equipment for the neonate. A neonate is a newborn infant up to six weeks of age. J Ex 13/2, 3.

84. The ambulance did not contain a fetal heart monitor or blankets to wrap a baby after delivery. Further, it did not have pitocin, a drug frequently used to control postpartum bleeding. I.G. Ex 3/2; I.G. Ex 7/36; I.G. Ex 10/33; I.G. Ex 12/36; Tr 44.

85. With hypertension as severe as Mrs. Rivera's, there was the possibility of fetal distress requiring the use of a fetal heart monitor. I.G. Ex 7/20, 21, 33, 36; I.G. Ex 10/19, 20, 33; I.G. Ex 12/36.

86. Without an external fetal monitor, a nurse could not detect partial placental abruption or fetal hypoxia. I.G. Ex 7/20, 21, 33; I.G. Ex 10/31; I.G. Ex 12/19, 32.

87. DeTar Hospital's transfer guidelines provide that it is the responsibility of the transferring physician to determine and order the utilization of appropriate personnel and equipment for transfer, and to determine and order life support measures necessary to stabilize the patient prior to transfer, and to sustain the patient during transfer. Dr. Burditt violated the hospital's guidelines as well as Section 1867. J Ex 3/2.

88. The ambulance arrived at DeTar Hospital at approximately 6:24 p.m. Dr. Burditt saw Mrs. Rivera being taken out on the stretcher to the ambulance, but did not re-examine her or inquire about her blood pressure. Stip B22; Tr 912, 917.

89. At approximately 6:50 p.m., the ambulance left DeTar Hospital with Mrs. Rivera, her husband, Nurse Nichols, and two E.M.S. attendants. Tr 42.

90. Mrs. Rivera was "transferred" within the meaning of Section 1867 of the Act, but her transfer was not an "appropriate transfer" within the meaning of Section 1867 of the Act. 42 U.S.C. 1395dd (e) (5) and (c) (2).

91. On December 5, 1986, John Sealy Hospital was a receiving hospital and had available space and qualified personnel for the treatment of Mrs. Rivera, but the transfer of Mrs. Rivera was not effected through qualified personnel and transportation equipment.

92. If Mrs. Rivera's baby had experienced fetal distress, the only way in which Nurse Nichols could have relieved it would have been to deliver the baby. I.G. Ex 7/21; I.G. Ex 10/31; I.G. Ex 12/20, 33.

93. A vaginal delivery in an ambulance decreases the possibility of the resuscitation of a baby in distress, and an obstetrical nurse is not trained or licensed to perform cesarean sections. I.G. Ex. 10/31; Tr 82; I.G. Ex 7/21, 33; I.G. Ex 12/20, 33.

94. Dr. Burditt knowingly transferred Mrs. Rivera without qualified personnel or transportation equipment in violation of Section 1867. 42 U.S.C. 1395dd.

95. A short time after departure from DeTar, Mrs. Rivera told Nurse Nichols that the baby had moved into position. The ambulance pulled to the side of the road near Ganado, Texas, approximately 30 miles from Victoria, and at 7:30 p.m. Mrs. Rivera gave birth to a healthy baby boy. Tr 43, 44; J Ex 1/43; J Ex 2/8.

96. The ambulance then proceeded to Ganado Hospital to obtain pitocin. J Ex 4/1; J Ex 1/44; I.G. Ex 3/7; Tr 44, 45, 71.

97. While at Ganado Hospital, Nurse Nichols telephoned Dr. Burditt to report the birth and request further orders. Dr. Burditt told Nurse Nichols to proceed to Galveston with Mrs. Rivera. Mrs. Rivera requested that she be returned to DeTar Hospital. Stip B23; J Ex 1/44; I.G. Ex 1/3; I.G. Ex 3/7; I.G. Ex 6/8.

98. Upon learning that Mrs. Rivera was returning to DeTar Hospital, Dr. Burditt refused to see her and told the house supervisor to dismiss her if she was stable and not bleeding excessively. I.G. Ex 1/3.

99. Dr. Burditt was asked if he would allow another doctor to examine Mrs. Rivera. When Dr. Burditt agreed, the house supervisor arranged for Dr. Pigott to assume the care of Mrs. Rivera. Stip B24; I.G. Ex 2/3.

100. Upon her return to DeTar Hospital, Mrs. Rivera and her baby were treated by Dr. Pigott. Stip B25.

101. Dr. Burditt did not re-examine Mrs. Rivera after his initial examination of her at 4:50 p.m., although he was standing at the nurses' station from 5:30 p.m. until 6:18 p.m. I.G. Ex 3/2; Tr 67, 134, 169, 170, 512, 832, 908, 909, 917.

102. The Admission Record of Mrs. Rivera indicates that with her prior deliveries her labor had been no longer than 24 hours in duration and that her contractions had started at 7:00 a.m. on December 5, 1986. J Ex 1/12.

103. Mrs. Rivera was considered a multiparous woman (a woman, who had previous births). I.G. Ex 7/4; I.G. Ex 10/4; I.G. Ex 12/5, 16. She was at high risk for rapid labor, being a multiparous patient with ruptured membranes, with a favorable cervix near term and with a smaller than usual fetus. R Ex 2/2.

104. At 4:50 p.m., the presenting part of the infant was at -3 and at 6:30 p.m. was -2. Mrs. Rivera had a positive nitrazine test consistent with the presence of leaking or ruptured membranes. I.G. Ex 7/4; I.G. Ex 10/4; I.G. Ex 12/5, 15; Tr 702.

105. There is no difference between ruptured and leaking membranes in relation to the subsequent development of labor. Tr 351, 352, 483, 487, 591, 763.

106. The generally accepted medical definition of labor is the progressive dilation of the cervix and the descent of the infant in relation to contractions of the uterus leading towards delivery of the infant. Tr 589, 764.

107. In obstetrics, "effacement" is the dilation of the cervix, enlarging the cross-sectional area of the birth canal to permit passage of the fetus. Taber's Cyclopedic Medical Dictionary, 16th Ed. 1985.

108. When the infant's head is "ballottable;" it means that the baby is still encased in fluid. I.G. Ex 7/30-31.

109. Small differences in measurement of the dilation of the cervix and the percentage of its effacement are subjective measurements, which can only be detected over time by the same examiner. Tr 512, 704, 915-16; I.G. Ex 7/30-31.

110. The I.G. did not prove by a preponderance of the evidence that delivery was imminent at the time Dr. Burditt signed the "Physician's Certificate Authorizing Transfer" of Mrs. Rivera.

111. The I.G. did prove by a preponderance of the evidence that, at the time of her departure, Mrs. Rivera was in labor and her delivery was imminent.

112. Dr. Burditt acted in reckless disregard of the truth or falsity of the information given to him by the nurses at DeTar Hospital and by not examining Mrs. Rivera before her departure from DeTar Hospital, and thus "knowingly" violated Section 1867 of the Act.

113. Mrs. Rivera was in labor at a time when a) her transfer posed a threat to the health and safety of herself and her unborn child, and b) there was inadequate time to effect a safe transfer to another hospital prior to delivery. 42 U.S.C. 1395dd (e)(2).

114. Dr. Burditt acted in reckless disregard of the threat to the health and safety of Mrs. Rivera and her unborn child in ordering her transfer to John Sealy Hospital, in violation of Section 1867. 42 U.S.C. 1395dd (e)(2).

115. Mrs. Rivera was in "active labor," within the meaning of Section 1867 of the Act, at the time Dr. Burditt signed the "Physician's Certificate Authorizing Transfer" and at the time of her transfer from DeTar Hospital. 42 U.S.C. 1395dd (e)(2).

116. When Mrs. Rivera came to DeTar Hospital at approximately 4:00 p.m., her blood pressure was 210/130; and at 4:50 p.m., when examined by Dr. Burditt, her blood pressure had not changed. Stip B8; J Ex 1/6.

117. The standard of care for the treatment of hypertensive pregnant women is a national standard among board certified OB/GYNs. Tr 315.

118. Treatment to lower blood pressure is well within the expertise of a board-certified OB/GYN, although Dr. Burditt had never seen a blood pressure at DeTar as high as 210/130. I.G. Ex 7/20; Tr 815, 816.

119. In his application for staff privileges at DeTar Hospital, Dr. Burditt requested and was granted privileges for the treatment of patients with severe pre-eclampsia and eclampsia. Pre-eclampsia is a toxemia of pregnancy characterized by increasing hypertension, headaches, albuminuria, and edema of the lower extremities. If a pre-eclamptic patient develops convulsions or convulsive seizures, she is designated as having eclampsia. J Ex 6/14; Taber's (supra).

120. Mrs. Rivera's blood pressure could be indicative of chronic hypertension, pre-eclampsia or pregnancy induced hypertension, or chronic hypertension with superimposed pre-eclampsia. I.G. Ex 7/9; I.G. Ex 10/8; I.G. Ex 12/4; Tr 354, 493.

121. Regardless of whether she was suffering from chronic hypertension, pre-eclampsia, or chronic hypertension with superimposed pre-eclampsia, Mrs. Rivera's blood pressure was extremely high and needed to be brought down immediately. I.G. Ex 7/7, 9, 12; I.G. Ex 10/8, 10; I.G. Ex 12/4, 13.

122. Blood pressure is considered abnormally high when the systolic is over 150 and the diastolic is over 90. I.G. Ex 7/6; I.G. Ex 1/6; I.G. Ex 12/7. By this

standard, Mrs. Rivera's blood pressure was extremely high and dangerous. I.G. Ex 7/9, 13; I.G. Ex 10/12; I.G. Ex 12/12; Tr 579.

123. In the case of a pregnant woman, if the systolic pressure is above 160-170, or the diastolic pressure is above 110, the mother and fetus are in serious danger. I.G. Ex 7/6, 7; I.G. Ex 12/7; I.G. Ex 10/6, 7. Hypertension is a leading cause of death in pregnant women. I.G. Ex 7/7; I.G. Ex 10/7.

124. If the systolic blood pressure is over 160, there is an increased risk of bleeding into the brain. Tr 345.

125. As a result of her hypertension, Mrs. Rivera and her fetus were at high risk of:

a. seizures, which would result in death to both the mother and child;
b. congestive heart failure;
c. heart attack;
d. serious kidney dysfunction or tubular necrosis;
e. stroke or intracranial bleeding, which could result in death, total or partial paralysis, blindness, loss of motor control or loss of speech;
f. placental abruption;
g. fetal hypoxia;
h. death to the mother and fetus.

I.G. Ex 6/6; I.G. Ex 7/7-10, 12, 13; I.G. Ex 10/6-10, 12; I.G. Ex 12/8, 9, 11, 13, 19; R Ex C/1; Tr 358, 501.

126. Mrs. Rivera's blood pressure was so high that it compromised her body's ability to transport oxygen to her brain, heart, and fetus, and her condition needed to be dealt with immediately. I.G. Ex 12/7, 9, 10; I.G. Ex 10/9; I.G. Ex 7/9-11; Tr 215, 233-34, 238, 262, 264, 274.

127. Mrs. Rivera had an "emergency medical condition" (hypertension) which manifested itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in placing her health in serious jeopardy, serious impairment to her bodily functions and serious dysfunction of certain bodily organs and parts, as defined by Section 1867(e)(1). 42 U.S.C. 1395dd (e) (1).

128. On December 5, 1986, Mrs. Rivera had an "emergency medical condition" (hypertension) as defined by Section 1867(e) (1) of the Act. 42 U.S.C. 1395dd (e) (1).

129. From 4:00 p.m. to 6:50 p.m., Mrs. Rivera had the following blood pressures: at 4:00 it was 210/130; at 4:50 it was 220/118; at 5:00, it was 210/130; at 5:10, it was 190/110; at 5:30, it was 173/105; at 5:45, it was 178/103; at 6:00, it was 186/107; and at 6:50, it was 190/110. Mrs. Rivera's readings of 210/130 (at 5:00 p.m.) and 190/110 (6:50 p.m.) mean that her condition was not stabilized either at the time Respondent examined her or at the point of her departure from DeTar Hospital. J Ex 1/7-9, 11, 13, 43; I.G. Ex 10/22.

130. Between 4:00 p.m. and 6:30 p.m., Mrs. Rivera's blood pressure varied, but it remained unstable and dangerously high. I.G. Ex 7/24-25, 27-29; I.G. Ex 10/22-23, 25; I.G. Ex 12/24-25, 27, 29.

131. Because the seriousness of her hypertension had not changed, Mrs. Rivera was subject to the same complications at the time of her transfer, except for seizures, as when she arrived at DeTar, (i.e., stroke, intracranial bleeding, heart attack, congestive heart failure, kidney dysfunction, placental abruption, and fetal hypoxia). I.G. Ex 7/26; I.G. Ex 10/24; I.G. EX 12/26-27.

132. There are several treatments for hypertension. An anti-hypertensive drug such as apresoline can be administered either inpartum or postpartum. The patient can be given bed rest in a calm environment for 6-8 hours or in a situation as here, when the hypertension is due to preeclampsia, the delivery of the baby will often improve the patient's condition. I.G. Ex 7/12 I.G. Ex 10/10; I.G. Ex 12/11.

133. Dr. Burditt had received training in the use of apresoline but was taught that it was contraindicated during the labor process. Tr 804, 805, 931.

134. Medical experts believe that with severe hypertensive patients such as Mrs. Rivera, a physician should administer an antihypertensive drug and that apresoline is the drug of choice. I.G. Ex 7/12, 14, Tr 777.

135. Dr. Pigott gave orders to administer apresoline to Mrs. Rivera after she returned to DeTar Hospital.

136. At most, magnesium sulfate may effect a variable and transient lowering of blood pressure in the case of women with preeclampsia or eclampsia. I.G. Ex 22/3.

137. Mrs. Rivera's emergency medical condition was not "stabilized" within the meaning of Section 1867 of the Act. 42 U.S.C. 1395dd (e)(4)(B).

138. At the time of Mrs. Rivera's transfer, Dr. Burditt did not have reasonable medical probability to conclude that "no material deterioration of her condition" was likely to result from her transfer to another hospital, within the meaning of Section 1867. 42 U.S.C. 1395dd (e)(4)(A).

139. Dr. Burditt knew when he ordered Mrs. Rivera's transfer and also at the time of her transfer that she had an "emergency medical condition" as defined by Section 1867(e) (1), and that her condition had not been "treated" or "stabilized."

140. The Respondent must prove mitigating circumstances by a preponderance of the evidence.

141. The I.G. must prove aggravating circumstances by a preponderance of the evidence.

142. It is the duty of the Administrative Law Judge (ALJ) to weigh the evidence presented and to determine the credibility of the evidence, especially evidence presented to the Court in the form of direct testimony.

143. The ALJ has the duty to balance all circumstances to determine the weight each will be given, and the effect it will have upon the penalty imposed.

144. In the present case there are both aggravating and mitigating circumstances proven by a preponderance of the evidence. Some, but not all, of these circumstances were taken into consideration by the I.G. in determining the amount of the penalty imposed against Dr. Burditt.

145. Mrs. Rivera's lack of prenatal care was a mitigating circumstance proven by a preponderance of the evidence.

146. Mrs. Rivera's lack of prenatal care is mitigating because of the effect it had on Dr. Burditt's decision to transfer her.

147. The fact that DeTar Hospital had no prior medical records on Mrs. Rivera is a mitigating circumstance proven by a preponderance of the evidence.

148. It is a mitigating circumstance that Dr. Burditt has instituted corrective measures to prevent this situation from arising again.

149. It is an aggravating circumstance that Dr. Burditt did not examine Mrs. Rivera after his initial examination.

150. It is an aggravating circumstance that Dr. Burditt did not read the copy of the law which was given to him by Nurse Herman.

151. It is an aggravating circumstance that Dr. Burditt did not attempt to consult another doctor.

152. It is an aggravating circumstance that Dr. Burditt did not treat Mrs. Rivera when she returned to DeTar Hospital after giving birth in an ambulance.

153. The appropriate amount of the civil monetary penalty is twenty thousand dollars ($20,000), based on the circumstances of this case.

DISCUSSION

Section 1867 of the Social Security Act was enacted to close the door on the shameful practice of denying emergency hospital care in the United States to many persons in dire need.[12] While most hospitals and physicians are committed to the ideal of providing access to quality health care for all, many hospitals had "forsaken their earlier commitment to patient access to health care for one of cost containment and restraint." H. R. Rep. No. 100-531, at 8, supra. Congress was appalled that many inappropriate transfers of patients in need of medical care from one hospital to another caused needless human suffering and death. Id. at 5-10.

Although this case does not represent an example of an illegal transfer motivated by the patient's inability to pay, it does present an example of a "responsible physician" who knowingly violated requirements of Section 1867 in a way that could have had tragic consequences for a mother and her unborn child. Luckily for all involved,

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[12] It was estimated that approximately 200,000 Americans were denied emergency hospital care each year, primarily for economic reasons, prior to the enactment of Section 1867. H. R. Rep 100-531, supra at 4.

there were no serious problems resulting from Dr. Burditt's violations.[13]

It is a tragedy that Dr. Burditt, a well-respected physician, a decent, personable man with loyal friends and patients, let his parochial interests and personal feelings (to limit his practice to low-risk patients and to avoid a potential malpractice lawsuit from a high-risk patient) interfere with his exercise of sound professional medical judgment. Dr. Burditt violated requirements of Section 1867 by transferring Mrs. Rosa Rivera from DeTar Hospital on December 5, 1986. While he never meant to harm Mrs. Rivera, he further compounded his initial recklessness, in ordering her transfer, by allowing his anger at having his authority challenged by nurses (and the resulting conflict with those nurses) close his mind to the merit of cancelling the transfer, all to the detriment of Mrs. Rivera and her unborn child. He depended on these same nurses for vital information in forming his diagnosis, but virtually ignored them when they attempted to warn him about Section 1867, a new federal law with which he was unfamiliar, and ignored their conclusions that the transfer of Mrs. Rivera and her unborn child and their transport in an ambulance for three hours was unsafe. His unyielding attitude did not allow him to consider whether he might be wrong, prompt him to investigate the nurses concerns, treat Mrs. Rivera before she was transferred, or treat Mrs. Rivera when she was returned to Detar Hospital. In this instance, although Dr. Burditt was not venal, he lost sight of his oath as a physician.

At the hearing, Dr. Burditt unsuccessfully attempted to justify his reckless disregard of Mrs. Rivera and her unborn child by presenting expert witnesses to establish that his actions on December 5, 1986 were based on sound medical judgment. Respondent's sound medical judgment contention and the expert testimony supporting that contention loses much of its persuasive force when one considers Dr. Burditt's failure to issue orders ensuring that the ambulance transporting Mrs. Rivera was properly equipped and when one considers his refusal to treat Mrs. Rivera and her baby following her return to DeTar Hospital after the delivery of her child in an ambulance. Finally, there were mitigating circumstances which had not been considered or given enough weight in the I.G.'s

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[13] This is due in no small measure to the nurses at DeTar Hospital, and especially Nurse Nichols' professionalism and abilities displayed in delivering a healthy baby boy on the side of the road in an ambulance.

Notice and which, upon being considered by this ALJ, compel a reduction in the civil monetary penalty sought by the I.G. These include the fact that, since this incident with Mrs. Rivera, Dr. Burditt has been engaged in efforts to prevent inappropriate transfers and to provide a clinic for indigent obstetric patients; the fact that Mrs. Rivera had not obtained any prenatal care prior to December 5, 1986; and the fact that DeTar Hospital had no prior medical records on Mrs. Rivera.

I. The I.G. Proved That Respondent Knowingly Violated Requirements of Section 1867 Of The Act On December 5, 1986.

A. Section 1867 Requirements.

Section 1867 was designed to prevent inappropriate transfers of patients in need of emergency medical care in the United States and established criteria for the treatment and safe transfer of any person with an "emergency medical condition" or any woman in "active labor." Section 1867 requires that a participating hospital and its responsible physician must:

> 1. provide a medical screening examination to determine if an individual has an emergency medical condition or is in active labor;
> 2. provide stabilizing treatment to any individual with an emergency medical condition or treatment to any woman in active labor prior to transfer;
> 3. if the hospital cannot stabilize the emergency medical condition, or treat the active labor, he or she may be transferred to another hospital only:
>
> > a. if the responsible physician certifies in writing that the benefits of the transfer outweigh the risks;
> > b. if the receiving hospital has space and personnel to treat the patient and has agreed to accept the patient;
> > c. if the transferring hospital sends medical records along with the patient; and
> > d. if the transfer is made with qualified personnel and in appropriate transportation equipment with necessary and appropriate life support measures.

A responsible physician in a participating hospital with an emergency department may be subject to a civil monetary penalty of up to $25,000 for each time the

physician knowingly violates any requirement of Section 1867. The hospital may also be subject to a civil monetary penalty of up to $25,000 for each violation.

B. Mrs. Rosa Rivera's Request For Medical Treatment.

Less than three years ago, late on a Friday afternoon, December 5, 1988, an indigent pregnant woman sought medical assistance from DeTar Hospital in Victoria, Texas. Victoria is a small, friendly community about two and one-half hours southwest of Houston on U.S. Route 59. Mrs. Rosa Rivera's blood pressure was alarmingly high that day-- higher than most at DeTar Hospital had ever seen. She was pregnant and close to having her sixth child. Her membranes had ruptured. She had been having contractions all day. She had not previously had any prenatal care. She was concerned for her life and for the life of her unborn baby. Mrs. Rosa Rivera was given an initial screening examination by an experienced labor and delivery nurse, Tammy Kotzur, at DeTar Hospital. When Nurse Tammy Kotzur discovered that Rosa Rivera's blood pressure was 210/130 she was alarmed and asked Donna Kiening, her supervisor and Head Nurse of the OB/GYN department, to come in and double check it because it was so extraordinarily high. The pressure was so unusual that Nurse Kiening noted it in an incident report.

C. Dr. Burditt's Initial Reaction To Mrs. Rosa Rivera's Two Medical Conditions.

Since Nurse Tammy Kotzur was concerned about Mrs. Rivera's blood pressure of 210/130, she telephoned Dr. Michael L. Burditt, Respondent, who was on call. Dr. Burditt, then Chief of the OB/GYN Department at DeTar Hospital, had worked with Nurse Kotzur in many obstetrical situations and trusted her judgment. Nurse Kotzur recited the alarming facts of Mrs. Rivera's conditions to Dr. Burditt who was on his mobile phone (she had intercepted him on his way to pick up his two daughters).

Dr. Burditt's reaction was immediate: he told Nurse Kotzur that he "didn't want to treat this lady" and ordered Nurse Kotzur to transfer Mrs. Rivera to John Sealy Hospital, approximately 160-170 miles away, in Galveston, Texas. When he told Nurse Kotzur that Mrs. Rivera "should be transferred to John Sealy Hospital," Nurse Kotzur asked if it was because of Mrs. Rivera's blood pressure, to which Respondent answered "yes." I.G. Ex 1/1.

Respondent's reaction prompted Nurse Kotzur to put him on hold, turn to Nurse Kiening, standing next to her, and tell her that Dr. Burditt wanted to transfer Mrs. Rivera to John Sealy Hospital. Nurse Kiening told her to ask Respondent to call back in about five to ten minutes, which she did, telling Dr. Burditt that she had to "check on a few things." I.G. Ex 1/1; Tr 124.

D. DeTar Hospital's Response To Dr. Burditt's Initial Orders.

Following Nurse Kotzur's phone call with Respondent, Nurse Kiening called Jean Herman, the Associate Director of Nursing, at about 4:25 p.m. I.G. Ex 2/2; Tr 83,85. Nurse Herman, Nurse Kiening's supervisor, was the "house supervisor" on December 5, 1986. Nurse Kiening informed Nurse Herman of Respondent's order to transfer and that she and Ms. Kotzur thought the transfer was unsafe. I.G. Ex 2/2; Tr 85, 124, 145, 148. Nurse Herman was concerned and asked Nurse Kiening to call Charles Sexton, the hospital administrator. She was asked to tell Mr. Sexton about the transfer and the nurses' belief that the transfer was unsafe. Nurse Kiening called Mr. Sexton and relayed that information. Nurse Herman did not instruct Nurse Kiening to proceed with transfer arrangements at that time, as hospital policy required that there be a receiving hospital and a physician to accept care before the hospital would initiate arrangements for a transfer. Neither a receiving hospital nor a receiving physician had yet been obtained. Nurse Kiening consulted the hospital administrator.

At approximately 4:30 p.m., Respondent called back and was directed to speak to Nurse Kiening. I.G. Ex 1/1; I.G. Ex 2/2; J Ex 1/8. When Respondent called Nurse Kotzur, as requested, she referred him to Nurse Kiening, who told him that the nurses felt that the transfer was unsafe and that he should talk to John Sealy hospital personally to arrange the transfer. She said that he also had to do a personal evaluation of Mrs. Rivera and he replied that he was enroute to the hospital for that purpose.

Nurse Kiening also asked Respondent for permission to start an IV or give magnesium sulfate. Respondent told Nurse Kiening that she could start an IV only if Mrs. Rivera could be transported by emergency medical services (E.M.S.), but that if she could not be transported by E.M.S., Nurse Kiening was not to start an IV, as Mrs. Rivera would have to be transported by private car. Nurse Kiening did not know whether E.M.S. was available, but she was sufficiently convinced that

Mrs. Rivera's high blood pressure required immediate treatment that she ignored Dr. Burditt's restriction and started an IV at 4:40 p.m. She also placed in the "physician's orders" portion of the medical records a 4:30 p.m. phone order, attributed to Dr. Burditt, to start an IV.

E. DeTar Hospital And Dr. Burditt Met Their Duty Under Federal Law To Provide For The Initial Screening Of Mrs. Rivera.

Dr. Burditt came to the hospital around 4:50 p.m. and examined Mrs. Rivera. He found her blood pressure to be 210/130. He was impressed that this was the highest blood pressure he had ever seen.

F. Dr. Burditt Knowingly Refused To Comply With The Requirements Of Section 1867.

Dr. Burditt knew that Mrs. Rivera and her unborn child were at severe risk of stroke and death unless her blood pressure was brought under control. At this point, Dr. Burditt should have realized that, on balance, the danger to Mrs. Rivera and her unborn child was far more important than his concern about minimizing the risk of a potential malpractice lawsuit. At this point, he should have begun to treat Mrs. Rivera's medical conditions. But, instead, after the initial examination and without ordering any treatment, he confirmed his order to transfer Mrs. Rivera and made arrangements for John Sealy Hospital to accept her. The nurses began a standard protocol for the administration of magnesium sulfate, a precaution against convulsive seizures, only after Dr. John Downing, a physician at John Sealy, instructed Dr. Burditt to do so.

G. The I.G. Proved By A Preponderance Of The Evidence That Dr. Burditt Falsely Certified That The Benefits Of Transferring Mrs. Rivera Outweighed The Risks.

1. Dr. Burditt's Reaction To Section 1867.

If it is determined that the individual has an "emergency medical condition" or is in "active labor," the hospital must provide treatment to "stabilize" the emergency medical condition or treat the labor, or transfer the individual to another medical facility only if appropriate and only by following the requirements in Section 1867.

The preponderance of the credible, probative evidence in the record supports the finding and conclusion that

Dr. Burditt knowingly ordered Mrs. Rivera's transfer although: (1) Mrs. Rivera was in "active labor" and transfer posed a risk to her health and safety and that of her unborn child; (2) Mrs. Rivera had an "emergency medical condition" that had not been stabilized; and (3) the benefits reasonably to be expected from appropriate treatment at John Sealy Hospital did not outweigh the risks of transferring her 160-170 miles by ambulance in her condition, accompanied only by a nurse and insufficient life support equipment.

At about 5:00 p.m., when Respondent recorded the results of his examination, Nurse Herman showed him a summary of Section 1867 of the Social Security Act. She told him that, because Mrs. Rivera was in active labor, he could not transfer her unless he signed a certification form, which she presented. He remarked that Mrs. Rivera was not in active labor, that she was in early labor, and told Nurse Herman to give him that "dang piece of paper." He signed the certification that the "medical benefits of transfer outweigh the risks," telling Nurse Herman that "until DeTar Hospital pays my malpractice insurance, I will pick and choose those patients that I want to treat."

I held in my Ruling of December 22, 1988 that the standard of liability here -- "knowingly" -- includes actual knowledge, reckless disregard, or deliberate ignorance. Thus, even if Respondent had not been made aware of the requirements of Section 1867, or did not act intentionally in violation of those requirements, he was liable for acting with reckless disregard or deliberate ignorance by not actually engaging in any meaningful weighing of the risks and benefits of transfer. Dr. Burditt is liable because he so carelessly ignored the relative weights of known risks to Mrs. Rivera and her unborn child when he ordered a transfer, the benefits of which depended on two fragile individuals surviving a 160-170 mile ride bereft of treatment. He acted in reckless disregard and deliberate ignorance of the requirements of Section 1867 and of the risks attending Mrs. Rivera's transfer.

The I.G. proved by a preponderance of the evidence that Mrs. Rivera's medical condition demanded that Dr. Burditt stabilize her hypertension and either delay the birth of or deliver her child. The parties disagreed as to whether or not he stabilized her and treated her labor prior to transfer.

2. The I.G. Proved That Dr. Burditt Transferred Mrs. Rosa Rivera While She Had "An Emergency Medical Condition" That Had Not Been "Stabilized."

As a result of her hypertension, Mrs. Rivera and her fetus were at high risk of death or serious medical problems, including:

(1) seizures which would result in death to both the mother and child;
(2) congestive heart failure;
(3) heart attack;
(4) serious kidney dysfunction or tubular necrosis;
(5) stroke or intracranial bleeding, which could result in death, total or partial paralysis, blindness, loss of motor control or loss of speech;
(6) placental abruption;
(7) fetal hypoxia; and
(8) death to the mother and fetus.

Dr. Burditt knew this when he ordered Mrs. Rivera's transfer. He does not dispute that he should have stabilized and treated her, but maintains that he did take these actions. The preponderance of the evidence is that he did not. Thus, Dr. Burditt violated a requirement of Section 1867.

Section 1867 required Mrs. Rivera's emergency medical condition to be stabilized and required her active labor to be treated because the risks outweighed the benefits of transfer and the transfer was not made with necessary and appropriate life support measures. By definition, "stabilized" means that "no material deterioration of the condition is likely, within reasonable medical probability, to result from the transfer of the individual from a facility." Section 1867(e)(4)(B).

The medical record shows that Mrs. Rivera arrived at DeTar Hospital in a dangerously hypertensive condition and remained that way through the time of her departure from DeTar Hospital. When Mrs. Rivera was actually transferred, her blood pressure was still very high. Dr. Crosby noted that it "went up and down like a roller coaster" from the time she came to DeTar Hospital through the time she was actually transferred.

Dr. Burditt admitted that he never re-examined or went in to check on Mrs. Rivera after the initial examination he made around 5:00 p.m. Tr 832, 908, 917. See also I.G.

Ex 3/2; Tr 67, 134, 169-70, 512. Further, he testified that when Mrs. Nichols discussed the laboratory results with him at 6:30 p.m., he asked only about Mrs. Rivera's cervical status; no mention was made of her blood pressure. J Ex 1/11; I.G. Ex 3/2; Tr 912.

Knowing that her blood pressure was critically high at 5:00 p.m. when he signed the "Physician's Certificate Authorizing Transfer," Respondent deliberately ignored or recklessly disregarded the need to check her condition at the time of her 6:30 p.m. departure in the ill-equipped ambulance. Respondent knew that Mrs. Rivera's high blood pressure placed her at high risk of stroke and maternal and fetal death. Knowing her condition, Respondent, nevertheless failed to provide any treatment which might have stabilized her blood pressure, such that, within a reasonable degree of medical probability, no material deterioration was likely to result from the transfer. Thus, her condition was not stabilized at the time he ordered the transfer at 5:00 p.m. nor at the time that she was actually transferred at 6:30 p.m.

Respondent's case is damaged by the attitude he displayed from the time he first examined Mrs. Rivera until the time she was transferred. His fear of having to defend himself against malpractice if he handled a high-risk obstetrical procedure, coupled with his anger at the nurses' resistance to his ill-considered decision to transfer Mrs. Rivera, took precedence over his obligation as a physician to use his ability and his judgment for the good of his patient. The Oath of Hippocrates states: I will prescribe regimen for the good of my patients according to my ability and my judgment and never do harm to anyone." As a result of his attitude, he never even reexamined her or learned what her blood pressure was, let alone whether it had been stabilized before Mrs. Rivera left DeTar Hospital.

Dr. Burditt could have ensured that no material deterioration in Mrs. Rivera's condition was likely to occur as a result of the transfer by stabilizing her hypertension and treating her active labor. The hospital administered magnesium sulfate, and I find, as Respondent correctly contended, that this was an appropriate means of lowering the risk of convulsions. That it did not stabilize Mrs. Rivera's blood pressure, or even temporarily reduce it below the danger level, is not surprising. Four expert witnesses (including Dr. Burross, one of Respondent's experts, Dr. Pigott, a medical fact witness for Respondent, and Respondent himself) all testified that magnesium sulfate is not primarily an anti-hypertensive drug. Tr 238, 338-89,

391, 480, 651, 719-20, 874; I.G. Ex 12/13, 27, I.G. Ex 7/13-14. Respondent noted that blood pressure had been lowered in some patients when the administration of magnesium sulfate had been accompanied by bed rest, but he acknowledged that the bed rest was most likely what caused that result. This view is consistent with the observation made by Dr. Warren Crosby, one of the I.G.'s experts, that:

> the magnesium was given in an appropriate amount and in an appropriate way so that the risks of convulsions was reduced, but her blood pressure was not reduced. I think it was necessary to treat the blood pressure and to keep the patient at bed rest for a period of time until she met the criteria for "stabilization." That's another one of those terms that's difficult to define, but basically, . . . It needs, who knows, 24, sometimes, 6 [hours], it just depends upon the patient. But I don't think I ever saw somebody in which I was satisfied with one or two or three hours of observation. Tr 384-85.

I found further support that magnesium sulfate alone is not the cause for a reduction in blood pressure in the statement of Dr. Pritchard of Parkland Hospital (Dallas). Dr. Pritchard had done studies on whether magnesium sulfate lowers blood pressure, writing in a well-recognized work on obstetrics and gynecology, Williams Obstetrics (17th ed 1985) at p. 552 concluded:

> The myth is perpetuated that parenterally administered magnesium sulfate is a potent antihypertensive agent. . . . Many studies in hypertensive human subjects, beginning with those of Winkler and co-workers (1942) in chronically hypertensive subjects and Pritchard (1955) in women with preeclampsia-eclampsia, have identified at most a variable and transient lowering of blood pressure during bolus administration of sizeable doses of the compound!

Respondent's decision to transfer Mrs. Rivera violates Section 1867 because Mrs. Rivera's hypertension simply was not stabilized using magnesium sulfate alone. Respondent tried to suggest that the transfer was appropriate in these circumstances because an alternative modality of treatment, apresoline, was unacceptable. Respondent was trained in the use of apresoline, but he testified that he would not use apresoline in a birth situation because of risk to the fetus. He mistakenly relies on Dr. Crosby's testimony that apresoline could cause a precipitous drop in blood pressure and result in

an anoxic insult to the unborn. Respondent inaccurately represents Dr. Crosby as characterizing this as a strong possibility, whereas Dr. Crosby actually testified that the benefits of apresoline are 98 percent while the risks are only two percent, and that this is a very acceptable drug which is used all over the world. Tr 379, 404-05.

3. The I.G. Proved That Dr. Burditt Transferred Mrs. Rosa Rivera While She Was In "Active Labor."

Dr. Burditt contends that Mrs. Rosa Rivera was in early labor when he transferred her and that Section 1867 does not require treatment for "any phase" of labor. R Rep Br 5. Dr. Burditt argues, in effect, that the applicable definition of "active" labor is "the progressive dilation and effacement of a woman's cervix leading to child birth." R Rep Br 3,4. He maintains that "the evidence at trial showed no effective movement or increase in the dilation and effacement of Rosa Rivera's cervix" while she was at DeTar Hospital. R Rep Br 5.

As I noted earlier in this Decision, Section 1867 does require treatment of a woman in active labor prior to transfer unless the transfer is made with qualified personnel in appropriate transportation equipment with necessary life support measures.[14]

The definition or interpretation of a word or phrase in a federal statute is a matter of federal law and should be viewed in light of the purpose for which Congress enacted the federal statute. See Chapman v. Houston Welfare Rights Organization, 441 U.S. 600, 608, (1979); United

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[14] Several other requirements must also be met, i.e.:

1. the responsible physician must certify in writing that the benefits of the transfer outweigh the risks;
2. the receiving hospital must have space and personnel to treat the patient and must have agreed to accept the patient; and
3. the transferring hospital must send medical records along with the patient.

All three of these requirements were met here, although, as discussed elsewhere in this Decision, the certification by Respondent was incomplete and without basis in fact.

States v. Allegheny Co., 322 U.S. 174, 183 (1944); United States v. Anderson Co., Tenn., 705 F.2d 184, 187 (6th Cir., 1983), cert. denied, 464 U.S. 1017 (1984). Accordingly, I must interpret the word "active labor" in light of the purpose which it was designed to serve as a matter of federal law.

By enacting Section 1867, Congress intended to prevent hypertensive women who are pregnant and in "active labor" from being inappropriately transferred. Congress wanted such "active labor" to be treated.

The term "active labor" is defined by Section 1867 (e)(2) as labor at a time at which--

(a) delivery is imminent,
(b) there is inadequate time to effect safe transfer to another hospital prior to delivery, or
(c) a transfer may pose a threat of the health and safety of the patient or the unborn child.

Mrs. Rivera was in active labor within the meaning of Section 1867 at the time Dr. Burditt ordered her transfer at 5:00 p.m. and at the time of transfer itself, at 6:30 p.m. Tr 87, 102, 115; I.G. Ex 7/29-33; I.G. Ex 10/27-31; I.G. Ex 12/29-33.

First, the best evidence that delivery was imminent is that Mrs. Rivera delivered approximately 30 minutes after she left DeTar Hospital. Whether the dilation and effacement of Mrs. Rivera's cervix had progressed to a more active phase immediately prior to transfer cannot be established conclusively because Respondent deliberately ignored his responsibility to personally re-examine her immediately prior to transfer at 6:30 p.m., thus continuing his reckless disregard of her unsuitability for transfer. Even aside from the obvious fact of her delivery almost immediately after leaving DeTar Hospital, the results of Dr. Burditt's earlier examination and her reported symptoms up to the point of departure indicated the strong possibility that birth would occur before Mrs. Rivera could complete the long ride to John Sealy Hospital.[15] At 4:50 p.m., when Dr. Burditt examined Mrs. Rivera, he found that she was three centimeters dilated, sixty percent effaced, at a -4/-3 station, the membranes

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[15] Nurse Nichols' report at 6:30 p.m. that the cervix was still only three centimeters dilated seemingly supports Respondent's argument. However, these other symptoms should have prompted Respondent to check the measurement and examine Mrs. Rivera.

were over the head of the fetus and fluid was palpable. The largest of her previous children was eight to nine pounds at birth, and Dr. Burditt estimated the fetal weight of this one at six pounds. At 5:00 p.m., when the transfer certification was signed, Mrs. Rivera was having contractions every three to four minutes, of moderate intensity, and lasting forty seconds. J Ex 1/8; I.G. Ex 2/2. When Respondent examined her at around 5:00 p.m., the fetus' head was ballottable. By 6:30 p.m., the head had moved down to a minus two station. J Ex 1/6, 7, 11; Tr 243, 512. At 5:30 p.m., Mrs. Rivera's contractions were noted as occurring every three to five minutes. At 6:24 p.m., they were three minutes apart. At 6:30 p.m., they were every three minutes, lasting thirty seconds each. J Ex 1/9, 11; J Ex 5/2. At 6:30 p.m., Mrs. Rivera was experiencing regular contractions. I.G. Ex 7/24; I.G. Ex 10/21-22; I.G. Ex 12/23; Tr 240, 243.

Thus, Respondent had information which made it necessary for him to personally re-examine Mrs. Rivera before letting her depart for a 160-170 mile ride to another hospital. He cannot rely on his failure to re-examine Mrs. Rivera to counter the overwhelming evidence that delivery was imminent.

Even if I accept that the dilation of the cervix had not progressed and that this factor alone might support a conclusion that birth was not imminent, the statutory definition of active labor was met here in this case. The preponderance of the evidence is that the safe transfer of Mrs. Rivera prior to delivery could not have been effected during the entire time needed to complete the lengthy 160-170 mile trip to John Sealy Hospital. Mrs. Rivera had had five previous deliveries (i.e. she was multiparous) and thus the measurement of her cervix or any other single factor or even a combination of factors could not be relied upon to predict the time of delivery. The frequency and regularity of contractions and the leaking of fluid from membranes were enough to indicate that delivery might occur during the ambulance ride. The fact that it occurred so early in the ride removes any doubt about this conclusion.

Finally, this meets the Section 1867 definition of "active labor" because there is no doubt that the transfer posed a threat to the health of Mrs. Rivera and the fetus. This threat might have been offset and the transfer justified if Respondent had examined and treated Mrs. Rivera appropriately, but he did not. He did not stabilize her hypertension, control the progress of her delivery, examine her immediately prior to transfer to assure that she could safely be moved, or even assure

that the transport vehicle was properly equipped for its urgent mission. Dr. Burditt knowingly transferred Mrs. Rivera when it posed a risk to her health and safety and to that of her unborn child. Dr. Burditt himself wrote that Mrs. Rivera was at severe risk of stroke or death and that her unborn child shared those risks. I.G. Ex 6/6; Tr 858.

Mrs. Rivera was in "active labor" within the meaning of Section 1867 if any of the elements of the statutory definition were met. As discussed above, all three elements were proved here by a preponderance of the evidence. Thus, Respondent was in violation of Section 1867 by transferring Mrs. Rivera without treating her active labor to ensure safe delivery of her unborn child.

4. The I.G. Proved that, Dr. Burditt Transferred Mrs. Rosa Rivera "Without Qualified Personnel and Transportation Equipment."

Finally, in his haste to rid himself of the responsibility to care for Mrs. Rivera, Respondent failed to ensure that the ambulance was appropriately equipped with trained personnel or essential life support equipment. Given the risks to which she and her unborn child were subject in the uncontrolled environment of an ambulance, a physician should have accompanied her. At the very least, Respondent should have ensured that the ambulance was equipped with a fetal heart monitor, the drug "pitocin" to stop postpartum hemorrhaging, and a blanket to wrap the newborn. Thus, given that Mrs. Rivera's hypertension had not been stabilized and given that she was in "active labor" under the definition in Section 1867, the failure of Respondent to assure that Mrs. Rivera was transported in a properly staffed and equipped ambulance is sufficient under Section 1867 to make her transfer inappropriate and a violation of Section 1867.

For this alone, Dr. Burditt is subject to a civil monetary penalty.

II. The I.G. proved that on December 5, 1986, Dr. Burditt was a "responsible physician," as defined by Section 1867 of the Act.

For the reasons stated here and in my December 22, 1989 Ruling, Respondent is a "responsible physician" within the meaning of Section 1867 of the Act as a matter of federal law.

Section 1867(d)(2) of the Act provides:

> . . . the term "responsible physician" means, with respect to a hospital's violation of a requirement of this section, a physician who--
>
> > (A) is employed by, or under contract with, the participating hospital, and (B) acting as such an employee or under such a contract, has professional responsibility for the provision of examinations or treatments for the individual, or transfers of the individual, with respect to which the violation occurred.

42 U.S.C. 1395dd(d)(2).

Thus, the requirements of Section 1867 apply to the actions of physician "employed by" or "under contract with" a participating hospital who exercise professional responsibility for the transfer of an emergency patient, as here.

The Respondent argues that he is not "employed by" or "under contract with" DeTar Hospital. The Respondent contends that (1) he can't be an employee of the hospital because he would then be engaged in the corporate practice of medicine, a prohibited act in Texas, and (2) although he has medical staff privileges at DeTar Hospital, he is not "under contract with" the hospital because medical staff bylaws have never been accorded the status of a contract under Texas law, especially with regard to private hospitals. DeTar is a private hospital.

As stated earlier, it is axiomatic that the interpretation and definition of a federal statute and its terms is controlled by federal and not state law. Also, a phrase in a federal statute, such as the phrase "responsible physician," must be interpreted and defined in light of the purposes for which Congress enacted it. Chapman v. Houston Welfare Rights Organization, 441 U.S. 600, 608, (1979). Conversely, a conclusion that a Texas physician is "under contract with" a hospital, as that term is defined in Section 1867 of the Act, is not a definition of that term under State legislation.

I conclude that, as a matter of federal law, if a staff physician acts to fulfill a hospital's duties to provide emergency services to the community as a condition of maintaining his privileges at a hospital, the physician is acting "under contract with" that hospital for the purposes of Section 1867(d)(2) of the Act. To hold otherwise would defeat the principal purpose for which

Section 1867 was enacted, to prevent the inappropriate transfer of poor and disadvantaged persons from hospital emergency departments. A definition which does not include such a key actor in violation of the requirements of Section 1867 would make Section 1867 of the Act ineffective against violations; Congress certainly did not intend such a result. Also, I am influenced by the fact that the American Medical Association characterizes medical staff bylaws as a binding contract between the medical staff and the hospital:

> Medical staff by-laws adopted and approved by the parties constitute a contractual undertaking that is equally binding on the governing body and the medical staff as long as they continue to conform to law and are not shown to risk loss of hospital accreditation.

AMA House of Delegates Report, Legal Status of the Hospital Medical Staff Proceedings (June 1986). The fact that Congress recently amended Section 1867 to clarify this issue, as pointed out by the Respondent in his December 16, 1988 brief, serves to reinforce my interpretation.

DeTar Hospital must follow the requirements of Section 1867 of the Act by delegating to qualified physicians, nurses, and other qualified medical personnel the duty to determine whether a candidate for transfer has an "emergency medical condition" or is in "active labor." They must decide whether a patient would be better cared for at another facility and, if so, whether that patient can withstand the dangers of transfer.

Congress clearly recognized that hospitals would be relying on the judgment of physicians and provided for a civil monetary penalty against a "responsible physician" for a hospital's knowing violation of the statute. As a member of the active medical staff and Chief of OB/GYN, Dr. Burditt made certain promises, agreeing that if he were granted staff privileges, in return he would be bound by the hospital by-laws and the rules and regulations of the medical staff.

DeTar Hospital's benefits to Respondent and the other members of its active medical staff are the right to admit patients to the hospital without limitation and to command the resources of the hospital, its facilities, and employees for the care of those patients. In exchange for these benefits, Respondent promises to take part in the care and treatment of "unaligned" obstetrical patients. Respondent's mutually dependent and mutually

beneficial relationship with DeTar Hospital is contractual. In exchange for the privilege of admitting his patients without limitation, and the privilege of commanding the resources of the hospital staff and facilities to care for and treat them, without which he could not effectively earn his livelihood, Respondent agreed to perform services for DeTar Hospital, among them the care of unaligned obstetrical patients.

The I.G. alleges, and the Respondent apparently does not dispute, that the Respondent agreed to treat unaligned obstetrical patients who came to DeTar's emergency room, and the hospital agreed to allow the Respondent to admit his own patients and to use the hospital's personnel and resources to treat them. Thus, Respondent is a "responsible physician" within the meaning of Section 1867.

III. The Amount of the Civil Monetary Penalty, as Modified, is Reasonable and Appropriate Under the Circumstances of this Case.

The evidence in the record proves that the amount of the penalty should be reduced because of mitigating circumstances. Mitigating circumstances are those circumstances which "do not constitute a justification or excuse of the offense in question but which, in fairness and mercy, may be considered as extenuating or reducing the degree of moral culpability." (Emphasis added) Black's Law Dictionary 1153 (4th ed. 1968)

I held that the Regulations set forth guidelines to be followed in this case in determining the amount of the penalty to be imposed against Dr. Burditt. The language of Section 1867(d)(2)(B) calls for a civil money penalty of up to $25,000 for "each violation". It is the duty of the ALJ to consider and weigh the circumstances proven by a preponderance of the evidence, and to determine the weight each will be accorded in determining the penalty to be imposed. In the present case, there are both mitigating and aggravating circumstances proven by a preponderance of the evidence. Some, but not all, of the mitigating circumstances were taken into consideration by the I.G. in determining the amount of the penalty imposed against Dr. Burditt. Also, there were some mitigating circumstances the I.G. considered but did not accord the same weight which I do. Those circumstances which were not considered and which were given lesser weight are significantly mitigating to require a reduction in the penalty imposed against Dr. Burditt.

The evidence in this case proves that Dr. Burditt's unfortunate reaction to Mrs. Rivera's medical conditions was influenced by her lack of prenatal care and, in particular, the absence of a prior medical history of her condition. His fear of being the subject of a malpractice action was intensified by the presence of her serious hypertension and the absence of any medical evaluation and history of her hypertension, and the fact that she had not previously been under the care of a physician regarding her pregnancy. One of the predominant benefits of prenatal care is the opportunity for early recognition and treatment of hypertension. Mrs. Rivera testified during the hearing that she had been advised of the potential for hypertension at the time of her pregnancy with her fifth child. Given these factors, his culpability in recklessly disregarding and deliberately ignoring the requirements of Section 1867 is lessened. Of course, he remains liable for his ill-considered decision to transfer Mrs. Rivera.

These circumstances were not mentioned in the I.G.'s Notice of Determination. They are mitigating circumstances proven by a preponderance of the evidence and require a reduction in the proposed penalty.

Dr. Burditt testified that he had made a decision to limit his practice to low-risk patients because he was a solo practitioner. The obvious fear of malpractice suits unfortunately influenced his decision in this case.[16] He also testified that he was divorced and that one of the considerations in limiting his practice to low-risk patients was to be able to spend more time with his teenage daughter, who lived with him. Although these circumstances are understandable, they do not relieve him from his liability for violation of Section 1867, nor do they diminish his culpability for actions on December 5, 1986, with respect to Mrs. Rivera. Dr. Burditt was on call and accepted the responsibility of being called to the emergency room of DeTar Hospital and of having to treat someone who was a high-risk patient. Doctors simply do not have the luxury of not treating someone in Mrs. Rivera's condition and situation. The fear of malpractice suits and the financial burden of high malpractice insurance costs are nationwide problems,

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[16] Although is not in the record of this case, I am aware of reports in the television and print media of the unfortunate fact that some obstetricians have retired or stopped delivering babies because of concerns over malpractice suits. Fortunately for his community, Dr. Burditt has continued to practice OB/GYN in Victoria.

which all doctors must face and solve through concerted action and in cooperation with governmental entities.[17]

Dr. Burditt argues that the distraction of having to treat another unaligned emergency patient (Mrs. Ramirez) at the same time is a mitigating circumstance. Dr. Burditt's treatment of Mrs. Ramirez is proof that he does not transfer patients solely because they are unaligned. In fact, Respondent introduced a list of the unaligned patients he has treated. However, he was not totally occupied with Mrs. Ramirez's delivery until 6:18 p.m. He had more than enough time for the crucial last-minute pre-transfer examination he should have performed on Mrs. Rivera, as well as the time to treat Mrs. Rivera's condition. The presence of another unaligned patient requiring emergency treatment does not diminish Respondent's culpability. Dr. Burditt was capable of handling and could be expected to handle, such a responsibility as the "on call" physician. Also, there were two other physicians present who could have assisted him, and one of these doctors did help deliver Mrs. Ramirez's child.[18] Dr. Burross, one of Respondent's expert witnesses, commented that Dr. Pigott, who was also on call, should have been asked to help.

Finally, Dr. Burditt also testified that he has been engaged in extensive efforts to prevent this kind of situation from occurring in the future. He testified that he has utilized both his time and services to attempt to improve the transfer system since 1986, and has worked to establish a networking system with surrounding tertiary hospitals. Dr. Burditt further testified about his participation in local efforts to provide care for indigent obstetric patients. These patients will have a prenatal record which will provide patients, such as Mrs. Rivera, the prenatal care necessary to ensure safe delivery of their babies and prenatal records to assist doctors in the early diagnosis and treatment of such conditions as hypertension. Corrective steps within the meaning of the Regulations

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[17] Physicians may have the right to limit their practice to low-risk patients if they wish, but, by reason of Section 1867 of the Act, they cannot do so as a "responsible physician" at a Medicare participating hospital with an emergency department.

[18] Respondent testified that because of the history of his relations with one of the two, it was not likely that this physician would have agreed to help him. This is no excuse for him not making the request.

have been taken by Dr. Burditt. These are commendable and constitute mitigating circumstances proven by a preponderance of the evidence. They were either not considered by the I.G. or considered significant enough by the I.G., and this requires a reduction in the penalty imposed.

There are aggravating circumstances which the I.G. considered and accorded proper weight. In the Notice of Determination, dated April 26, 1988, the I.G. states that the "obstetrical nurses at DeTar Hospital attempted to dissuade Dr. Burditt from transferring Mrs. Rivera but were unsuccessful." The Notice properly lists this, Respondent's failure to re-examine Mrs. Rivera, and his refusal to treat her upon her return to DeTar Hospital as factors which enhance his culpability.

Section 1867 of the Social Security Act is aimed at deterring certain conduct, rather than penalizing a hospital or doctor. The penalties are designed to insure that a violation does not happen again and that efforts are made by doctors and hospitals to ensure this goal. In the present case, it would appear that these efforts have been made by Respondent and DeTar Hospital and that, in the time since this incident arose, women in Mrs. Rivera's situation and their unborn children have not been put at risk because of the lack of prenatal care.

The maximum civil monetary penalty that could have been imposed under Section 1867-- $25,000 for each violation--could have been higher in this case.

I conclude that a civil monetary penalty of twenty thousand dollars ($20,000) is appropriate under the circumstances of this case.

ORDER

Based on the evidence in the record and Section 1867 of the Act, it is hereby Ordered that Respondent pay a civil monetary penalty of twenty thousand dollars ($20,000) for his violations of Section 1867 on December 5, 1986.

/s/

Charles E. Stratton
Administrative Law Judge