

**APPLICATION OF EMERGENCY MEDICAL
TREATMENT AND ACTIVE LABOR ACT (EMTALA)
IN THE TREATMENT OF THE MENTALLY ILL**

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I. Introduction

I would like to thank the Commission for inviting me to participate in the briefing on patient dumping. I am an attorney in private practice and for the last 35 years have given advice to and represented hospitals and other health care providers in a variety of civil litigation matters. I do not profess to be an expert in the issues being considered by the Commission but hope that I can provide a “boots on the ground” perspective to the issues that arise in enforcement of EMTALA when patients with mental illness present to hospital emergency rooms.

II. The Emergency Medical Treatment and Active Labor Act

“Patient dumping” has been referred to in the scholarly literature as any economically motivated transfer of a patient from a hospital capable of providing care to another facility. It encompasses the “ways in which healthcare providers attempt to avoid treating unprofitable patients.” The legislative history and plain language of The Emergency Medical Treatment and Active Labor Act (hereinafter EMTALA) clearly indicate that the statute was enacted to address only a subset of patients: those presenting to hospital emergency departments with emergency conditions who are either declined treatment or transferred to other hospitals on the basis of inability to pay. EMTALA imposes legal responsibilities on those hospitals receiving Medicare reimbursement to provide an adequate medical screening evaluation, stabilizing treatment and appropriate transfer of patients presenting to the emergency department. Its requirements apply equally to all patients, including those with mental disorders.

Despite EMTALA’s stated purpose, The United States Supreme Court has held that sanctions for violations of EMTALA, including imposition of damage awards, fines and decertification from participation in Medicare, do not require proof of an economic motivation where the allegation is failure to stabilize. Roberts v. Galen of Va., Inc., 525 U.S. 249 (1999) (in private cause of action against hospital for failure to stabilize, proof of improper motive by hospital in failing to provide necessary stabilizing treatment not necessary). *See also* Tolton v. Am. Bioydne, Inc., 48 F.3d 937 (4th Cir. 1995) (EMTALA not limited to patients who are indigent or uninsured). On the other hand, at least one federal circuit interpreting EMTALA requires proof of an improper motive before a hospital can be liable for damages for failure to screen. *See* Cleland v. Bronson Healthcare Grp., Inc., 917 F.2d 266, 268 (6th Cir. 1990); Estate of Lacko v. Mercy Hospital, Cadillac, 829 F.Supp. 2d 543 (E.D. Mich. So. Div. 2011). Whether that circuit’s interpretation of the screening requirement will survive given the Supreme Court’s decision in Roberts v. Galen, *supra*, remains to be seen.

EMTALA has fulfilled an important function in providing access to emergency care for the indigent and uninsured, of which the mentally ill are

disproportionately represented. Application of its requirements to the mentally ill, however, is difficult, complex and often costly. It nevertheless has been my experience that hospitals and emergency medical practitioners have devoted considerable effort to educate themselves and their staff on the statute's requirements especially as it pertains to the treatment of the mentally ill. They have adopted processes, policies, and devoted resources to addressing the challenges of fulfilling the purpose and letter of the law in this context. Review of some of EMTALA's core mandates, the cases interpreting them and practical considerations of implementation illustrate some of the issues.

A. Medical Screening Evaluation

Under EMTALA, “[i]f any individual...comes to the emergency department and a request is made on the individual's behalf for examination or treatment of an emergency medical condition, the hospital must provide for an **appropriate** screening examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition...exists.” Further, “[a] participating hospital may not deny provision of an appropriate medical screening examination required under subsection (a) of this section...in order to inquire about the individual's method of payment or insurance status.” Hospitals may ask about insurance before the screening examination but may not delay or condition the examination on the ability to pay or the existence of insurance. *See and compare* Correa v. Hospital San Francisco, 69 F.3d 1184 (1st Cir. 1995 (delay of screening examination many hours after registration during which hospital learned patient was a member of an HMO was a violation of EMTALA. Delay so egregious to effectively qualify as a refusal to treat) *with* Parker v. Salina Regional Health Center, Inc., 463 F. Supp. 1263(D. Kan. 2006)(where patient had cardiac arrest 20 minutes after arrival, and clerk had asked about insurance just prior to arrest, there was no EMTALA violation for failure to screen). As a practice, many hospitals do not ask about insurance until after the screening exam is completed. They also document insurance or lack thereof on separate documents than registration records. They also record the times the registration records are created and the times the documents on which the availability of insurance are created to remove any doubt as to whether the exam was conditioned on ability to pay.

What is an “appropriate medical screening examination” is not defined by the statute. The interpretative guidelines in the State Operations Manual define “appropriate medical screening examination” as one “reasonably calculated” to determine whether an emergency medical condition exists. It is, according to the Manual, “the process required to reach, with **reasonable clinical confidence**, the point at which it can be determined whether the individual has an EMC or not. An MSE is not an isolated event. It is an ongoing process.” Importantly, it must “be the

same MSE that the hospital would perform on any individual coming to the hospital's dedicated emergency department with those signs and symptoms." "If a hospital applies in a nondiscriminatory manner...a screening process that is reasonably calculated to determine whether an EMC exists, it has met its obligations under EMTALA."

Psychiatric patients are physically sicker than those without such illness because of decreased access to health care, homelessness, malnutrition, substance abuse and the effects of psychotropic medications. At least half of psychiatric patients have medical conditions that warrant further evaluation and treatment. Many may have medical conditions causing or exacerbating their psychiatric symptoms. Conversely, what may appear to be a purely psychiatric condition may be physical illness with no psychiatric precedent, such as substance abuse, endocrine disorders, medication errors or malnutrition. Conducting an appropriate screening examination is critical and presents its own special challenges. EMTALA requires that hospitals provide a medical screening examination for both a medical condition and psychiatric condition if perceived to be present. Whether a specific psychiatric evaluation must be done depends on the individual's presentation and the facility's capability. As the Operations Manual states, "[d]epending on the individual's presenting signs and symptoms, an appropriate MSE can involve a wide spectrum of actions... ." The Final Report of the Technical Advisory Group on EMTALA to HHS recommended that " HHS describe that an MSE should attempt to determine whether an individual is gravely disabled, suicidal or homicidal. 'Gravely disabled' implies a danger to oneself due to extremely poor judgment or inability to care for oneself." This recommendation was not incorporated into CMS' interpretative guidelines. Nonetheless, hospitals are counseled to, at the very least, inquire about and to document assessment of the risk of harm to self or others in patients with mental disorders (*e.g.*, disorientation, aggression, suicidal/homicidal ideation) because such conditions, if present, are in most cases emergency medical conditions requiring stabilization or transfer.

The difficulty practitioners face when presented with symptoms of psychiatric illness are evident by a number of cases brought for civil damages arising from harm because either a psychiatric or a medical condition was not discovered, despite appropriate screening evaluations. *See, e.g., Jackson v. East Bay Hosp.*, 246 F.3d 1248 (9th Cir. 2001)(hospital satisfied screening obligation under EMTALA although it failed to detect that the patient was suffering from drug toxicity and not only a psychiatric problem); *Eberhardt v. City of Los Angeles*, 62 F.3d 1253 (9th Cir. 1995)(conducting screening evaluation comparable to other patients manifesting similar symptoms resulting in treatment for heroin overdose but not patient suicidality did not violate EMTALA); *Baber v. Hospital Corp. of America*, 977 F.2d 872 (4th Cir. 1992)(no EMTALA violation found in patient who presented with psychiatric symptoms who was screened, treated and appropriately transferred to a psychiatric hospital even though a neurologic condition from a fall

sustained while in the emergency department was not discovered leading to patient's death. The court declined to decide if a second screening evaluation is needed when new symptoms arise after a patient presents to the emergency department); Gerber v. Northwest Hosp. Ctr., Inc., 943 F. Supp. 571 (D. Md. 1996)(patient presenting with physical complaints who reported her complaints were so unbearable she felt suicidal, appropriately screened although underlying psychiatric condition leading to attempted suicide not detected).

EMTALA does not require a provider to be correct in his diagnosis only that their screening be nondisparate based upon the patient's presentation. Indeed, the interpretative guidelines specifically state, "The clinical outcome of an individual's condition is not a proper basis for determining whether an appropriate screening was provided." In spite of the limitations of the statute, however, a surveyor will often cite a facility for failing to provide an appropriate MSE if an undetected condition subsequently results in a bad outcome. Hospitals and physicians are frustrated that CMS's enforcement stance is often directly opposite the interpretation of the law by federal courts and sometimes to CMS's own interpretative guidelines.

A medical screening must be administered within the capabilities of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether an emergency medical condition exists. A hospital is not required to have the capability to perform mental health screening and may rely upon mobile screening units or county health departments to conduct such screening. That provision of the statute has not prevented hospitals from being sued, however, even if unsuccessfully. *See e.g., Baker v. Adventist Health, Inc.*, 260 F.3d 987 (9th Cir. 2001)(where hospital did not have mental health professionals on staff, hospital not required to conduct mental health screening itself but could call the county mental health department to perform screening for psychiatric emergency); *Esperanza v. Sunrise Hosp. Med. Ctr., LLC, et al.*, 2011 WL 2747154 (D. Nev. 2011) (motion for summary judgment granted with regard to Plaintiff's EMTALA claims arising out of a suicide of a patient being held in a discharge and observation unit waiting for mobile mental health unit to determine if the patient should be admitted to a psychiatric facility where undisputedly the hospital did not have the capability of performing mental health evaluations). Even when such services are available, EMTALA may have reduced the available pool of psychiatrists willing to treat patients in the hospital where they may have to take call from the Emergency Department, because of the perceived threat of additional liability imposed by EMTALA.

On the other hand, many hospitals have responded to the increased demand for mental health evaluations in the ED by creating psychiatric emergency rooms within their facilities in which psychiatric patients are screened by psychiatrists or other designated providers after organic conditions have been screened in the main

emergency room. Some hospitals have dedicated space within an existing emergency department for mental health patients where screening, monitoring, and stabilizing treatment of such patients can be performed more safely. Specialty providers designated as qualified medical personnel to perform screening evaluations such as psychiatric social workers, mental health counselors, and psychiatric nurse practitioners have been hired, with psychiatrists on call as needed. Still others have adopted specialized screening protocols to be used in patients with psychiatric illness designed to close any gaps in training that exist among various health professionals on emergency department staff regarding the detection of psychiatric illness as well as organic causes of psychiatric symptoms. Some commentators caution against adopting such guidelines, however, because if not followed to the letter they become the basis for a citation or claim of disparate treatment and failure to adequately screen, even if there is a clinical basis for deviating from such policies. *See Hoffman v. Tonnemacher*, 425 F.Supp.2d 1120 (E.D. Cal. 2006)(hospital may have liability under EMTALA if it did not follow its own policy on appropriate screening evaluations).

B. Emergency Medical Condition

The activating condition requiring treatment to stabilize or transfer after the performance of the medical screening evaluation is discovery that an emergency medical condition exists. Actual knowledge of the emergency medical condition is required. It is not a violation of EMTALA that the providers should have discovered an EMC but failed to do so. *Burd v. Lebanon HMA, Inc.*, 756 F. Supp. 2d 896 (D M.D. Tenn. 2010)(no cause of action for EMTALA arising from suicide where providers concluded that the patient had acute anxiety that was stable, and did not require admission). An “emergency medical condition” means a medical condition manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in: (i) placing the health of the individual in serious jeopardy, (ii) serious impairment of bodily functions, or (iii) serious dysfunction of any bodily organ or part.

Under the interpretative guidelines, “an individual expressing suicidal or homicidal thoughts or gestures, if determined dangerous to self or others, would be considered to have an EMC.” But, one can be a danger to self or others constituting an emergency medical condition warranting stabilization or transfer even though not suicidal or homicidal. *Thomas v. Christ Hosp. and Med. Ctr.*, 328 F.3d 890 (7th Cir. 2003)(summary judgment in favor of hospital reversed where district court concluded no emergency medical condition was present because the patient was not thought to be suicidal stating, “One can imagine many situations in which an individual with a psychiatric impairment poses a threat to others without being suicidal or homicidal. Such an individual might cause great destruction without intending to do so, simply because he or she is not aware of or cannot control his or her own actions.”) The American Psychiatric Association at one time suggested

that the definition be revised to include psychiatric symptoms that “indicate an assessment of suicide, or homicide attempts or risk, disorientation, or assaultive behavior that indicates danger of self or others.” The touchstone of the APA suggestion was, as in current regulations, the question of whether a patient is a danger to self or others but more explicitly directed providers to consider behavior beyond suicidal or homicidal threats or ideation. Similarly, The Technical Advisory Group (TAG) also recommended that HHS generate specific examples or vignettes to shed more light on aspects of psychiatric EMCs causing confusion.

C. Stabilization

If an emergency medical condition exists, hospitals must provide: (A) within the staff and facilities available at the hospital, for such further medical examination and such treatment as may be required to stabilize the medical condition, or (B) transfer the individual to another medical facility in accordance with subsection (c) of the act.

Stabilization is defined as “to assure with a reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer.” Once stabilized, moreover, the hospital and physician have fulfilled their duties arising under EMTALA.

The stabilization and transfer requirements of EMTATLA are the crucibles for providers treating patients with mental disorders in the emergency department. The interpretative guidelines state:

To be considered stable the emergency medical condition that caused the individual to seek care in the dedicated ED must be resolved, although the underlying medical condition may persist.

....

An individual will be deemed stabilized if the treating physician or QMP attending to the individual in the emergency department/hospital has determined with **reasonable clinical confidence** that the emergency medical condition has been resolved.

The word “resolved” is not defined. Further, “stabilization” under EMTALA is a legal term. “Stable” or “stability” as used by physicians in clinical practice may not carry the same meaning as “stabilized” under EMTALA. Potential violations of EMTALA take place when physicians use “stable” to describe a patient who has an unstabilized emergency medical condition. *See Moses v. Providence Hospital and Medical Center, Inc.* 561 F.3d 573 (6th Cir. 2009)(patient deemed “stable” and discharged although psychiatric symptoms and diagnosis present from presentation

persisted, created dispute of fact whether EMC present defeating entry of summary judgment for hospital).

Whether a psychiatric patient is “stable” as defined by EMTALA, moreover, can be very subjective and cannot be documented like physical conditions can be by objective testing such as blood draws, CT scans or other treatment. Stabilizing treatment may involve question and answer sessions, “de-escalation” techniques and periodic monitoring, taking time and more staff resources. It is the subjectivity of the determination of stability that makes EMTALA so difficult to apply in the psychiatric context. Ultimately, it is where the duties of EMTALA and professional standards of care enforceable under state law may intersect. However, enforcement actions may depend on a retrospective analysis of whether a patient was actually stabilized, not whether a reasonably competent physician prospectively should have concluded the patient was stabilized.

With regard to psychiatric patients, the interpretative guidelines state:

Psychiatric patients are considered stable when they are protected from injuring or harming him/herself or others. The administration of chemical or physical restraints for purposes of transferring an individual from one facility to another may stabilize a psychiatric patient for a period of time and remove the immediate EMC but the underlying medical condition may persist and if not treated for longevity the patient may experience exacerbation of the EMC. Therefore, practitioners should use great care when determining if the medical condition is in fact stable after administering chemical or physical restraints.

In essence, the guidelines contemplate that if a patient is a threat to self or others temporizing measures such as chemical or physical restraints may provide stabilization until the patient can be admitted to an inpatient unit for definitive treatment. Yet, those measures themselves are subject to scrutiny which limits their use and potentially prolongs the time to appropriate inpatient or other placement.

Once a patient is stabilized, however, “hospitals may seek authorization for all services from a patient’s health plan, as long as doing so does not delay the implantation of the required MSE and stabilizing treatment”. One continuing problem encountered by emergency departments particularly in the treatment of patients with mental disorders, is simply that insurance plans are not accessible at night, weekends or during snowstorms to obtain authorization for placement of stable patients, leading to delays in disposition from the emergency department, increased costs to monitor and stabilize and the inevitable ripple effect for all patients presenting to the emergency department.

Hospitals are prohibited from discharging patients to non hospital facilities for purposes of complying with State law if such patients have not been screened and, if needed, stabilized. If, however, “after conducting the MSE and ruling out an EMC (or after stabilizing the EMC) the sending hospital needs to transfer an individual to another hospital...designated by...State or local laws” it may then do so. Id.

The shortage of inpatient psychiatric beds and outpatient community psychiatric services for patients in the emergency department means longer emergency department length of stays for the mentally ill, and sometimes leads to the boarding of psychiatric patients, particularly in the pediatric and adolescent populations for whom inpatient beds are the fewest. The absence of community and inpatient resources for hospitals to definitively treat the mentally ill leads to consumption of precious emergency department resources because ED personnel spend their time locating proper placements for such patients. Inescapably, staffing needs are increased so patients with mental illness can be closely monitored while awaiting inpatient admission. In an attempt to facilitate inpatient psychiatric placement from the emergency department, Maryland hospitals having inpatient beds have formed a voluntary bed registry via a website. Not all hospitals participate in the registry because of the time necessary to maintain the information and for fear that CMS may use it in enforcement actions against those supplying information.

To give some perspective on the magnitude of the problem arising from the lack of inpatient resources, and its impact on emergency room care of the mentally ill in Maryland, the Department of Mental Health for the State of Maryland reported that there were 69,649 emergency department visits related to behavioral health conditions in FY 2010. Obviously not all the conditions included in this figure were patients who were a threat to self or others requiring inpatient treatment. It is noteworthy nevertheless that there are only 1,102 acute care hospital and private psychiatric hospital beds in Maryland, and not all of them staffed. While there are five State run psychiatric facilities, these are long term treatment facilities limited almost exclusively to forensic admissions. While psychiatric patients who are a danger to self or others should certainly be stabilized and admitted, the demands of such patients in terms of unreimbursed costs, use of resources and consequential limitations in access to care for other patients, needs to be considered in the scope of the requirements imposed by EMTALA.

D. Duties of Receiving Hospitals

“A participating hospital that has specialized capabilities or facilities... shall not refuse to accept an appropriate transfer... if the hospital has capacity to treat the patient.” Acute care hospitals with psychiatric beds and psychiatric hospitals

alike are required to accept patients in transfer if they have capacity. Hospitals can be liable in civil actions for damages for “reverse dumping.” St. Anthony Hospital v. U.S. Dep’t H.H.S., 309 F.3d 680 (10th Cir. 2002)(refusal to accept unstable patient where specialty hospital had capacity was violation of EMTALA). Recently, CMS, at least in the region Maryland is located, has required hospitals with psychiatric units to consider any request for an inpatient bed from other hospitals’ emergency departments, as if it were coming from their own emergency department, presumably to prevent a hospital from holding beds for patients in its own emergency department and thereby potentially giving preference to insured patients. Some hospitals maintain a “request for bed log” to document when requests are received and strictly admit in the order requests are received, except when acuity of condition may take precedence. In light of this requirement, some hospitals do not even permit their own medical staff to directly admit to their psychiatric units but require all to “get in line.” More transfers of psychiatric patients has been the result.

E. Inpatients

Since 2003, CMS has interpreted the scope of EMTALA to end once a patient is admitted for an unstabilized emergency medical condition, so long as the admission was in good faith and not with the intent to avoid liability. A proposed rule change to extend EMTALA to patients admitted from the emergency department with an unstabilized emergency medical condition that was not stabilized before their discharge from an inpatient stay, was not adopted after extensive public comment. Similarly, the Agency declined to add a provision that would have required a receiving hospital with specialized capabilities and the capacity to treat, to accept a patient covered by EMTALA who had been admitted to an outside hospital but who remained unstable with an emergency medical condition. The agency noted that while some commentators advocated extending EMTALA to inpatients who do not experience a period of stability, there was no evidence that existing policies resulted in patients being admitted and then subsequently discharged before they were stable, adversely affecting the clinical outcomes of those patients. Further, under existing policy, numerous hospital conditions of participation protect patients' rights and adequate remedies exist under state law. Commentators also noted that the policy adopted in 2003 regarding inpatients achieves Congress’s intent by insuring that every individual regardless of their ability to pay has access to emergency services provided in hospitals with emergency departments.

The agency noted that many comments were made in opposition to proposals that would have extended EMTALA’s responsibilities to specialty hospitals accepting transfers of unstabilized inpatients who had come in from the emergency department. Opponents argued that such an extension would negatively impact treatment by potentially encouraging patient dumping and inappropriate transfers,

especially to teaching hospitals or tertiary care centers and urban safety net hospitals. It would also create disparate obligations with respect to inpatients being transferred because any EMTALA obligation would not apply to those patients who had been directly admitted to inpatient units and who did not come through emergency departments in the referring facility. Most specialty hospitals, it was observed, already accept inpatient transfers without being required to do so. Finally, commentators further asserted that finalizing the CMS policy as proposed would exacerbate confusion around the determination of whether an individual is considered stable.

CMS guidelines emphatically emphasize the obligation of hospitals to appropriately treat patients once admitted.

A hospital continues to have a responsibility to meet the patient emergency needs in accordance with hospital CoPs at 42 CFR part 482. The hospital CoPs protect individuals who are admitted, and they do not permit the hospital to inappropriately discharge or transfer any patient to another facility. The hospital CoPs that are most relevant in this case are as follows: emergency services, governing body, discharge planning, quality assurance and medical staff.

If during an EMTALA investigation there is a question as to whether an individual was admitted so that a hospital could avoid its EMTALA obligation, the SA surveyor is to consult with the RO personnel to determine if the survey should be expanded to a survey of the hospital's CoPs.....If it is determined that the hospitals admitted the individual solely for the purpose of avoiding its EMTALA obligation, then the hospital is liable under EMTALA and may be subject to further enforcement action.

There continues to be a dispute at the federal circuit court level on the topic of EMTALA's application to inpatients. The 6th Circuit Court of Appeals has found that "once a patient is found to suffer from an [EMC] in the emergency room, she cannot be discharged until the condition is stabilized", extending EMTALA's reach to inpatient conditions. Thornton v. Southwest Detroit Hosp., 895 F.2d 1131, 1134 (6th Cir. 1990); Moses v. Provident Hosp. and Med. Ctrs., Inc., *supra*. By comparison Bryan v. Rectors and Visitors of the Univ. of Va., 95 F.3d 3489 (4th Cir. 1996); Bryant v. Adventist Health Systems/West, 289 F.3d 1162 (9th Cir. 2002) and Harry v. Marchant, 291 F.3d 767 (11th Cir. 2002)(*en banc*) concluded that EMTALA obligations end once an unstable patient has been admitted to the hospital, even if not subsequently stabilized before discharge.

Commentators on this subject argue that the 6th Circuit's view is contrary to the statutory language and Congress' legislative intent, and does nothing less than

establish standards of care on a federal level -- something the Act was never intended to do. Considering the national shortage of inpatient psychiatric beds, any extension of EMTALA to inpatients appropriately admitted could be extremely problematic for emergency rooms and inpatient psychiatric units alike.

V. Incidence and Nature of EMTALA Violations

One of the consequences of the shift of care of the mentally ill from long term inpatient hospitals to the outpatient setting has been an increase in emergency department visits by those with mental disorders. In 2003, it was estimated that 2.5 million emergency room visits were attributed to treating mental disorders. Emergency Department use by patients with mental illness certainly has not declined in the last decade.

Although millions of patients are seen in the emergency department for mental health conditions each year, the number of complaints, enforcement actions, and lawsuits for EMTALA violations are miniscule by comparison. A June 2001 GAO Report, Emergency Care - EMTALA Implementation and Enforcement Issues, Report to Congressional Committees (June 2001) reported CMS regional offices had directed state survey agencies to investigate about 400 hospitals per year and it cited about half of them for EMTALA violations. (*Id.* at 3). Even if every single violation was related to a person with a mental disorder that would have represented .00008 of all patients seen in the emergency department for mental disorders (assuming 2.5 million visits as in 2003). Although data is difficult to come by on the incidence of complaints and confirmed violations (because such data is only available pursuant to a FOIA request) an uptick in overall complaints has been reported. Because enforcement of EMTALA is complaint driven (both by patients, their families and mandatory reporting of known violations by hospital ERs and receiving hospitals) those numbers may admittedly underestimate the incidence of violations that in fact occur. Current numbers of total complaints could not be located in time for this presentation except that violations resolved through a settlement agreement with OIG since 2002 have declined from a high of 30 in 2003 to an average eight a year since 2009. Although small in number, 17% of the patients involved in the settled enforcement actions from 2002-2013 appeared to involve patients with mental health issues.

Private causes of action for civil damages recoverable under state law can be brought by patients against hospitals harmed by EMTALA violations. Mental health issues are well represented in such suits. *See e.g.*, Baber v. Hosp. Corp. of America, 977 F.2d 872 (4th Cir. 1992) Baker v. Adventist Health, Inc., 260 F.3d 987 (9th Cir. 2001); Burd v. Lebanon HMA, Inc., 756 F. Supp. 2d 896 (M.D. Tennessee 2010); Caristo v. Clark Regional Med. Ctr., Inc., 2009 WL 2710094 (E.D. Ky. 2009); Carlisle v. Frisbee Memorial Hosp., 152 N.H. 762, 888 A.2d 405 (2005); Eberhardt v. City of Los Angeles, 62 F.3d 1253 (9th Cir. 1995); Esperanza v. Sunrise Hosp. Med.

Ctr., LLC., 2011 WL 2747154 (D. Nev. 2011); Gerber v. Northwest Hosp. Ctr., 943 F. Supp. 571 (D. Md. 1996); Guzman-Ibarguen v. Sunrise Hosp. and Med. Ctr., 2011 WL 2149542 (D. Nev. 2011); Jace v. Contra Costa County, 2009 WL 2248472 (Cal. Gt. App. Calf. 2009); Jackson v. East Bay Hosp., 246 F.3d 1248 (9th Cir. 2001); Jinkins v. Evangelical Hosp. Corp, 336 Ill. App. 3d, 377 (2002); Estate of Lacko v. Mercy Hosp., Cadillac, 829 F. Supp. 2d 543 (E.D. Mich. 2011); Lanman v. Kalamazoo Psychiatric Hosp., 2006 WL 73747 (2006); Lee v. Hennepin County, 2013 WL 6500159 (D. Minn. 2013); Moses v. Provident Hospital and Med. Ctr., Inc., supra; Pettyjohn v. Mission-St. Joseph's Health System, Inc., 21 F. Appx. 193 (4th Cir. 2001); Thomas v. Christ Hosp. and Med. Ctr., 328 F.3d. 890 (7th Cir. 2003); Tolton v. American Biodyne, Inc., 48 F. 3d. 937 (6th Cir. 1995); Williams v. Board of Regents of the University of New Mexico, 2014 WL 59866 (D.N.M. 2014). The Office of the U.S. Courts does not maintain the total number of cases filed alleging EMTALA violations in federal courts. The overall numbers of such lawsuits are certainly small when compared to the number of state court actions for medical malpractice. For example, in Maryland alone, at least 500 cases of alleged medical malpractice from all sources have been filed every year since 1988.

Significantly, many actions seeking damages under EMTALA alleging failure to perform an appropriate medical screening evaluation involving patients with mental health issues did not survive motions to dismiss or for summary judgment, because plaintiffs failed to allege or prove violations of federal law, although state causes of action for medical malpractice for failure to diagnose may have been appropriate under the same facts. *See, e.g., Baber v. Hosp. Corp. of America, supra* (failure to discover neurologic emergency medical condition not a violation of EMTALA. "While EMTALA requires a hospital emergency department to apply its standard screening examination uniformly, it does not guarantee the emergency personnel will correctly diagnose a patient's condition as a result of the screening."); Eberhardt v. City of Los Angeles, supra (failure to discover decedent's alleged suicidal tendency not a violation of EMTALA where a screening evaluation was identical to that provided in similarly situated patients but may violate state law); Gerber v. Northwest Hosp. Ctr., Inc., supra (patient complaining of tinnitus that was so unbearable that she felt like killing herself failed to prove a cause of action for EMTALA for failure to discover independent underlying psychiatric problems; allegations "may well support a claim for negligent failure to diagnose"). Pettyjohn v. Mission-St. Joseph's Health System, Inc., supra (patient's suicide six days after release from ER that had concluded patient was not actively suicidal after screening for this condition, at most stated medical malpractice claims). Nonetheless, costs associated with defense of unmeritorious claims is substantial. Because many hospitals are now self-insured, every dollar in defense or in settlement of such claims is a dollar not available to be spent on patient care.

Causes of action alleging failure to stabilize, however, have survived motions to dismiss and for summary judgment, particularly when the question of whether

there was an emergency medical condition requiring stabilization was either uncontested or disputed. *See, e.g., Carlyle v. Frisbee Memorial Hospital, supra* (patient complaining of suicidal ideation after drinking arrested at the direction of emergency room physician for “protective custody,” after patient refused to see a counselor from an organization that treated patients with mental illness, violated EMTALA for failing to stabilize the patient; verdict for Plaintiff affirmed); *Lee v. Hennepin County, supra*, (motion to dismiss denied when plaintiff told nurse she was suicidal, was escorted out of the emergency room by security without a screening exam or treatment. Patient’s statement that she did not want to be seen “with that attitude” of a psychiatric evaluator was not as a matter of law a refusal by the patient to be seen); *Moses v. Providence Hosp. and Med. Ctrs., Inc., supra* (dispute of fact existed whether patient who killed spouse after discharge had EMC or was stabilized); *Thomas v. Christ Hosp. and Med. Ctr., supra* (dispute of fact existed whether patient stable for discharge when hospital social worker concluded, contrary to discharging physician, that patient was a threat to others); *Williams v Board of Regents of the Univ. of N.M., supra* (EMTALA cause of action stated where patient determined to be danger to self or others, subsequently assaulted two staff members and was discharged to custody of police without stabilizing treatment). *But see Caristo v. Clark Regional Med. Ctr., Inc., supra* (facility that did not have capability to screen psychiatric illness and sought involuntary admission order to psychiatric facility did not fail to stabilize when it transferred patient at order of a court); *Jinkins v. Evangelical Hospitals, supra* (no cause of action for ER’s failure to stabilize where patient determined to be danger to self, placed in restraints, given Haldol and transferred by ambulance to State psychiatric facility which, after evaluation, released the patient determining he had alcohol related disorder).

Some of those cases that did survive a motion to dismiss or motion for summary judgment in the mental health context appeared to involve individual decision making by practitioners who were ignorant of EMTALA’s requirements or individual errors in judgment rather than provider or institutional motivation to avoid treating impecunious patients. *See, e.g., Carlyle v. Frisbee Memorial Hospital, supra; Lee v. Hennepin County, supra; Williams v. Board of Regents of Univ. of N.M., supra.* The academic literature contains reports of significant knowledge deficits of emergency department staff and on call physicians as late as 2006. CMS directs state surveyors to evaluate hospitals’ in-service training on EMTALA’s requirements, where knowledge deficits are identified during an investigation of a complaint. Many hospitals now require all staff to attend annual training courses on EMTALA’s requirements and to demonstrate their knowledge by testing as a condition of credentialing or employment in the ED.

Failures or refusals to administer emergency medical care under EMTALA to mentally ill patients because the patients were not able to afford such care are difficult to assess given the fact that the statute does not require economic motivation as an element for finding violations. Hints of such motivation in this

context are found in the case law regarding inpatient treatment. *E.g.*, Jace v. Contra Costa County, *supra*, (email sent three months after patient's death expressly stated that medical center "is not the admission hospital of choice for those with no insurance. Adults with no insurance should be referred to other hospitals unless...clinical reason to admit to [medical center] or there are no beds at of the contracted hospitals."); Moses v. Providence Hospital and Medical Center, Inc., *supra* (extending EMTALA duty to stabilize to an inpatient who had been admitted through the emergency room but discharged allegedly before stabilization; several days after admission the medical record reflected a recommendation that patient should be transferred to the psychiatry unit "if insurance will accept", but patient was discharged the following day by different physician who deemed patient stable for discharge).

The first academic review of confirmed EMTALA violations, limited to cases in fiscal year 2000, found denials of appropriate medical care rarely occur for an identifiable financial motive. Only 4% of 157 confirmed EMTALA violations were founded on an identifiable financial motive of refusal to treat, *i.e.* approximately 6 cases. Nonetheless, the study pointed out that financially motivated willful refusal of service continues to occur, supporting the importance of retaining the EMTALA statute to protect vulnerable populations. On the other hand, the authors also concluded that EMTALA has impact "beyond its original intent, leading to sanctions for some cases that may not represent willful refusal to screen or stabilize and to the cost associated with maintaining compliance with an unfunded mandate that threatens the continued viability of our nation's emergency medical system."

VI. Conclusion

EMTALA has largely fulfilled its mission to insure that patients, including those with mental illness, are not turned away from hospital emergency departments based on inability to pay. The regulations and the interpretative guidelines could certainly be improved in ways to better facilitate compliance and to better protect those with mental illness presenting to emergency departments. Recommendations for the types of symptoms to look for in medical screening evaluations, specific examples or vignettes to shed more light on aspects of psychiatric emergency medical conditions that cause confusion and more descriptors of what constitutes stabilization of psychiatric emergencies may be some changes to enhance compliance. But regulating all clinical decisions that vary greatly depending on the subtlety of each case is just not feasible. Of course, any change may have unintended consequences. The need for regulatory change cannot be separated from the systemic problems that plague access to health care for the mentally ill. Extending EMTALA to inpatients to address the alleged abuses so recently publicized in Nevada, for example, does not address the potential causes of that abuse, *i.e.*, the cost of care and the lack of comprehensive mental health services across the continuum of care. Finally, the Act was created to insure access

to emergency department care, not to guarantee correctness of care. In determining whether the regulations appropriately protect the mentally ill from dumping under EMTALA, these limitations should be kept in mind.

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