Hospitals' Obligations Under the Emergency Medical Treatment and Active Labor Act (EMTALA)

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Third-Party Plaintiffs May Bring a Federal Civil Suit Against a Hospital for Its Failure to Meet the Patient Medical Emergency Stabilization Requirements of EMTALA

In *Moses v. Providence Hospital and Medical Centers, Inc.*, 561 F.3d 573 (6th Cir. 2009), the U.S. Court of Appeals for the Sixth Circuit reversed the ruling of the federal district court which had granted defendant Providence Hospital's motion for summary judgment dismissing the Moses-Irons Estate's third-party claims brought against the hospital and its psychiatrist, Dr. Lessem. The Moses-Irons estate brought suit following Marie Moses-Irons' murder by her husband, Christopher Walter Howard, who had been released from the defendant hospital 10 days earlier, alleging that his care had failed to conform to the requirements of EMTALA.

Facts of the Case

Ms. Marie Moses-Irons took her husband, Mr. Howard, to the emergency room of Providence Hospital on December 13, 2002. In addition to having severe headaches, muscle soreness, high blood pressure, and vomiting, he was exhibiting slurred speech, disorientation, hallucinations, and delusions. She reported his symptoms as well as his threats toward her to the emergency room staff. He was admitted and evaluated in the hospital by a neurologist, an internist, and a psychiatrist. The neurologist noted that Mr. Howard was "acting inappropriately" and appeared to be "somewhat obtunded," but could not find overt signs of trauma. Ms. Moses-Irons had informed the neurologist that her husband had told her that he "had bought caskets." The neurologist recommended diagnostic procedures as well as a psychiatric evaluation. Mr. Howard was seen by psychiatry several times between December 14 and 17, and psychiatric hospitalization was recommended for "atypical psychosis" and "depression" so that "reality testing" could be conducted and observation made "for any indications of suicidal ideation or behavior" (*Moses*, p 573). However, without being admitted to the psychiatric unit, Mr. Howard was informed on December 18 that he was being discharged, with final diagnoses recorded as migraine headache and an atypical psychosis with delusional disorder. A note reported that he no longer had physical symptoms, had denied suicidal ideation, and had declined admission to the inpatient psychiatric unit. His wife's continued fear of him is also mentioned. He was discharged on December 19 because he "cannot stay as he is medically stable and now does not need 4E" (the inpatient psychiatric unit) (*Moses*, p 577). On December 29, he murdered his wife.

Ms. Johnella Moses, as the representative of the estate of her sister, Ms. Marie Moses-Irons, brought claims against Providence Hospital and psychiatrist Dr. Paul Lessem, pursuant to the Emergency Medical Treatment and Active Labor Act (EMTALA), 42 U.S.C. § 1395dd (2006) and common law negligence. Under the Act, any individual who seeks emergency treatment in a hospital that participates in Medicare and has an emergency department must be screened and evaluated to determine if an emergency medical condition exists; if so, the hospital must treat and stabilize the patient, either in its own facilities or by transfer to an outside facility.

The defendants sought summary judgment in the district court, relying on three arguments: that third parties did not have standing to sue under EMTALA, that a hospital's obligations under the Act end after admission of the patient to the hospital, and that an emergency situation had never been diagnosed in Mr. Howard. The district court granted summary judgment on the bases that he had been screened by the hospital, that he had been admitted to the hospital, and that no emergency medical condition was noted and thus, that EMTALA did not apply. The district court did not decide the third-party standing appeal. Ms. Moses appealed the grant of summary judgment.

There were several questions in the appeal to the Sixth Circuit. The first was whether third parties who were directly harmed by a hospital's failure to conform to the requirements of the Act had standing to sue under the civil remedy provision of the Act. The second was whether, under the Act, hospitals have the duty not merely to treat but also to stabilize the

patient. (Ancillary to this was whether the hospital's duties under the Act ended with admission of the patient to the hospital.) The final question was whether the civil remedy under the Act permits suits against individual physicians or instead is limited to actions against the hospital.

The appeal of the summary judgment was focused, most centrally, on the argument that the Act requires a hospital to continue to treat a patient after admission, until such time as the patient is medically stabilized. Ms. Moses, in her appeal and pleadings to the circuit court, included a defense expert report by a psychiatrist who had reviewed the case and concluded, as against the hospital's claim, that Mr. Howard did have an emergency medical condition when he arrived at the hospital and that it had not been stabilized by the time of discharge. This factual issue had not been presented to the district court because Ms. Moses had not received timely notice that the hospital intended to argue that no emergency condition existed.

Ruling and Reasoning

The court of appeals reviewed the district court's summary judgment ruling under the *de novo* standard of review. The two grounds for summary judgment, cited by the district court, were tested against the circuit court's reading of the EMTALA and the circuit court's determination of congressional intent in analyzing the language of the Act. In its analysis, the court concluded that it was the intent of Congress that the civil enforcement provision of EMTALA, § 1395dd(d)(2)(A), provide grounds for a third party to bring suit for civil damages if the petitioner met the requirement of being an ". . . individual who suffers personal harm as a direct result" of a hospital's violation of EMTALA (*Moses*, p 580, quoting 42 U.S.C. § 1395dd(d)(2)(A) (2006)).

Having held that the Act allows third-party civil claims if direct harm comes to the third party from a hospital's failure to meet the requirements of the Act, the court turned to the district court's second basis for granting summary judgment, to wit that a hospital's liability under EMTALA ends when a patient is admitted to the hospital or is transferred to another facility.

Again, the court undertook to apply the clear language and meaning of the Act and held that the Act requires that the hospital's obligation to the patient go beyond merely admitting the patient to the hospital. Instead the obligation requires that the hospital provide "such treatment as may be required to stabilize the medical condition," of the patient (*Moses*, p 581, quoting § 1395dd(b)). Holding that the district court's second basis for granting summary judgment was erroneous, the court then considered whether a psychiatric diagnosis meets the Act's definition of "an emergency medical condition" as being . . . a medical condition manifesting itself by acute symptoms of sufficient severity . . . such that the absence of immediate medical attention . . . placing the health of the individual . . . in serious jeopardy" (*Moses*, p 584, quoting § 1395dd(e)(1)(A)(i)). Applying the language of the Act and the undisputed facts in the instant case, the court stated: "We hold that a mental health emergency could qualify as an 'emergency medical condition' under the plain language of the statute" (*Moses*, p 584).

Having concluded that there was a factual issue concerning whether an emergency condition existed and finding that the hospital had an obligation under the Act to stabilize the patient, the circuit court reversed the district court and remanded those claims for further proceedings.

Next, the court looked to the district court's granting of summary judgment to Dr. Lessem. Again parsing the language of the Act, the court concluded that EMTALA's private civil damages provision provides a cause of action against hospitals, but not against individual physicians. The court reached this holding by noting that only the government enforcement provision, but not the civil provision, expressly provides for sanctions against individual physicians who violate provisions of the Act.

Discussion

The circuit court's parsing of the language of EMTALA expands opportunities for federal civil suits against hospitals. First, by allowing non-patient third parties who have arguably suffered injury as a result of a hospital's violation of its EMTALA duties, the domain of plaintiffs is enlarged. Third parties with causally remote injuries can bring suit for damages. In *Moses*, the murder of Mrs. Moses-Irons came 10 days after Mr. Howard's discharge. It becomes a factual issue as to whether her death was proximately caused by the 10-day-earlier release of Mr. Howard. If the *Moses* case goes forward to trial, there well may be opposing expert testimony on the question.

The expanded scope of liability created by *Moses* is not limited to harm caused by psychiatric patients. Hospital liability would similarly create a factual issue if, for example, a patient with a seizure disorder was seemingly stabilized in the hospital and then 10 days later had a seizure while driving and killed a bystander. In this example, as in *Moses*, there may well be opposing testimony on the liability question.

Second, the circuit court's holding that the Act requires a hospital to stabilize a patient, as opposed to simply admitting and treating, places a burden on physicians to predict accurately the prognosis of a patient and even more, the patient's future dangerousness. After all, some might argue that a patient has not really been stabilized if he decompensates soon after discharge from the hospital. It is arguably easier for physicians to approximate stability for patients with medical problems, where objective laboratory and imaging studies provide some measure of medical status. A patient admitted for seizures might be discharged after the EEG is normal and/or there have been no seizures for some time. However, there are no such objective data for psychiatric patients. Psychiatrists must rely on patient reports of mood and thought content. Sometimes, the report to a psychiatrist is colored by the patient's motive to be discharged from the hospital sooner than might be psychiatrically appropriate. Nonetheless, patients are not always adherent to the medications that stabilized them in the hospital, and sometimes medical and psychiatric problems recur even when patients are adherent. If such a patient harms another person 10 days after discharge from the hospital, secondary to recurrence of medical illness or psychosis while off of medication, should this make the hospital liable? At what point should psychiatrists in hospitals feel comfortable, legally, that their patients are not at risk for further deterioration? Should the report of a family member who claims to be afraid of a patient change a psychiatrist's decision to discharge a patient?

In short, psychiatric patients have less measurable and more unpredictable courses during and following their hospital stays, which puts psychiatric hospitals at higher risk for liability under the court's interpretation of EMTALA. Psychiatry as a field has generally been modest in describing its ability to predict future dangerousness, and empirical research justifies such modesty. Yet, in cases such as *Moses*, some plaintiffs' psychiatric experts engage in post-diction and are not so modest. This post-diction may have the consequence of imposing undue liabilities upon inpatient psychiatric practice.

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Scope of Juvenile Courts' Contempt Authority

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A Juvenile Court Does Not Have Statutory Authority to Impose Criminal Contempt Judgments on Parents or to Order Their Incarceration

In *In re Nolan W.*, 203 P.3d 454 (Cal. 2009), the Supreme Court of California considered whether a criminal contempt judgment and resultant imposition of a 300-day jail sentence handed down by the superior court, juvenile division, of San Diego County to Ms. W. for her failure to adhere to the voluntary drug treatment that was part of a parental reunification plan was authorized by the state statute that governed juvenile court proceedings (the Welfare and Institutions Code). The state's court of appeal had already determined in the instant case that the juvenile court's criminal contempt order was an abuse of discretion, but it did not reach the general question of whether the juvenile court had the authority to impose incarceration on a parent for failure to comply with the terms of a voluntary reunification plan (*In re Nolan W.*, 68 Cal. Rptr. 3d 242 (Cal. Ct. App. 2007)).

Facts of the Case

On the day of his birth, both Nolan W. and his mother, Kayla W., tested positive for amphetamines. Ms. W. admitted to using drugs and alcohol during her pregnancy and agreed that she needed residential treatment. The San Diego County Health and Human Services Agency then filed a juvenile dependency petition asserting that her substance usage constituted neglect of her child. The child was placed with a maternal aunt, and Ms. W. agreed to partici-