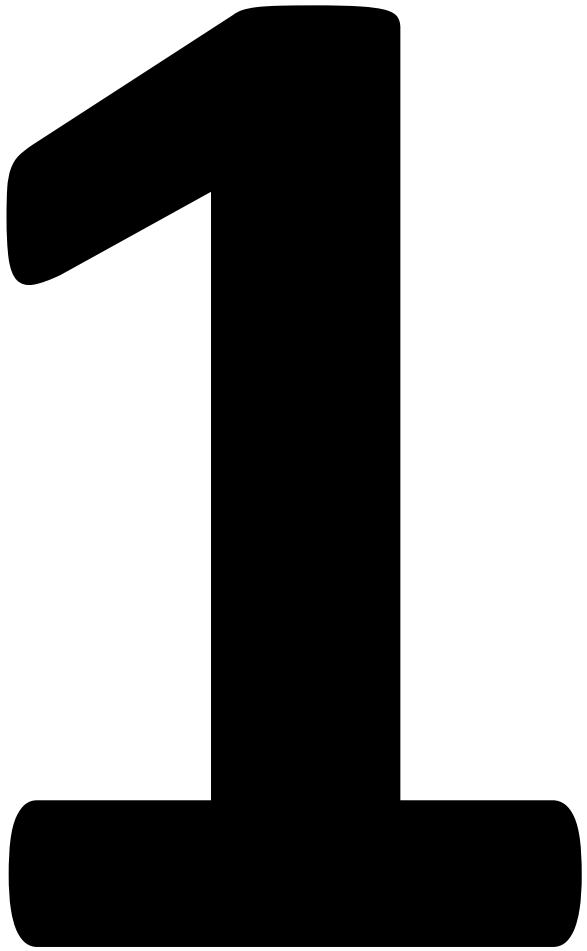
Quality& Liability

Fall 2017

Midterm Scoring

Midterm Scores 2017

	SA 1 (7)	SA 2 (7)	SA3 (7)	SA 4 (7)	SA 5 (7)	LA (25)
0317	5	6	6	4	5	12
0338	6	2	6	5	2	18
0473	4	4	2	0	3	4
0568	5	5	6	4	2	14
1200	7	5	6	4	5	15
1284	5	0	6	4	5	16
1310	5	6	6	3	5	15
1525	7	7	5	2	7	11
3243	0	5	6	7	5	5
3288	7	6	5	4	4	20
3273	5	7	7	4	2	14
3375	4	7	6	4	4	6
3337	5	7	2	4	6	18
3523	7	7	2	4	7	12
3581	4	3	7	3	5	8
4040	5	4	6	4	4	11
4161	5	3	7	5	7	17
4751	4	4	6	3	3	5
4753	7	5	6	3	5	13
5203	6	1	2	4	6	5
5363	5	6	6	4	2	17
5483	5	5	6	3	4	10
6166	5	5	6	4	5	8
6443	3	4	6	4	2	3
6586	7	0	5	4	2	18
6614	5	7	6	3	4	16
7348	4	4	5	3	4	4
7368	5	4	1	3	7	7
8523	5	5	6	4	5	17
????	5	6	6	4	2	8
AVERAGE						



The policies and procedures of a hospital provide: “In the event the Medical Screening Examination does not reveal an Emergency Medical Condition: Patient may be consulted by a financial counselor to obtain insurance information and/or to determine the means of payment of any further services the patient’s medical condition requires.”

Does having this policy or following this policy violate EMTALA? Why or why not?

No EMTALA duty at time, if **already** screened and no EMC.	5
Specific **prohibition** does not apply, because no delay.	2

2

After the mass shooting at a Las Vegas hotel, the emergency department at Las Vegas General Hospital was totally overwhelmed. It officially went on diversionary status. This is an accepted procedure. It notifies police and EMS that all available hospital resources are used and that they should transport individuals in need of medical attention to other facilities.

Whether negligently or intentionally, the Las Vegas Fire Department transported three patients to LVGH despite the diversionary status. The LVGH triage nurse tells the LVFD officers: “We are full. Take them to the hospital at the University of Nevada.” The LVFD does that.

Does this conduct violate EMTALA? Why or why not?

On hospital property **now**, even if not supposed to be.	2
Screening duty triggered.	2
H staff **caused** the transfer w/o screening.	1
Could have transfer with **certification** but did not	2

3

CC got an annual physical as a condition of her employment. The physician gave her a clean bill of health that allowed CC to continue working. Yet, just seven months later, another clinician diagnosed CC with very advanced lung cancer. CC subsequently died. CC's family sued the first physician for wrongful death for failure to diagnose her lung cancer or at least failure to apprise her of the diagnosis.

Assess the defendant's BEST response to this lawsuit.

No med mal claim, because no **treatment relationship**.	3
No treatment relationship, because **IME** exam	3
Possibly duty to warn, if actually knew (though no duty to diagnose)	1

4

Around 7:15 a.m. on the morning of Thursday, October 5, 2017, Christy called her neighbor who was a physician and told the neighbor that she might be having a heart attack. She was suffering from back pain, was having trouble breathing, and was sweaty. Christy did not call her regular healthcare provider located in another town (but in her PPO network), because she thought this was an emergency. While not a patient, Christy knew her neighbor's medical practice (while outside her PPO network) was only two miles away. The neighbor told Christy "to come over to her office and see her right away" but gave no other advice.

Christy arrived at her physician neighbor's medical office late Thursday afternoon. While Christy was sitting in the waiting room, she went into cardiac arrest. Though she was later resuscitated, Christy suffered brain damage from the incident and died three years later. Christy's family dues the neighbor physician for wrongful death caused by medical negligence.

Assess the defendant's BEST response to this lawsuit.

No duty to treat w/o treatment relationship.	1
Saying “come to office” was **sufficient** to induce reliance and form relationship.	3
But there was no **actual** reliance.	3

5

Is it “easier” for urban hospitals to comply with EMTALA, because of a temporal element in the definition of “stabilize”? In other words, if the transferee hospital is close (e.g. just blocks away) to the transferor hospital, then the transferor hospital may not need to provide as much treatment “to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer” because the transfer will be accomplished so quickly (e.g. before deterioration). Compare this EMTALA analysis to clinician termination of a treatment relationship. Is it analogously easier for urban clinicians to terminate with less notice?

Less “problem” based

More open-ended

Termination ideas.	2
EMTALA ideas.	3
Creative, clever observation.	2

EMTALA

Less likely to even “have” an EMC because can transfer quickly such that no “material deterioration” during transfer.

Lower travel time → less material deterioration → less likely EMC → fewer EMTALA duties

If really do have EMC, can satisfy pre-stabilization transfer certification, because risks from transfer **likely lower** given low duration

Termination

Notice period determined by ability to **find** replacement.

Likely to find replacement **faster** when more other physicians around.

But not necessarily true.

25

On Sunday evening, October 1, 2017, JC arrived at the North Memorial Hospital emergency department in Minneapolis, Minnesota. JC is a 76-year-old retired executive with the U.S. Postal Service. She was complaining of a burned mouth and throat. Because of its location, the North Memorial ED is always very busy. Consequently, before North Memorial screens individuals in its ED, it first triages them.

The lead triage nurse (an RN) examined JC and determined that she only had a sore throat that appeared mildly red. The assistant triage nurse explained: “This lady is saying that her mouth and throat were horribly burned by the ‘Men in Orange.’ She wants us to report her ‘injuries’ to the police. She wants to see a specialist. But I do not see anything wrong with her other than the sore throat. I think this lady is a little ‘funny.’” The lead triage nurse agreed and gave JC a lower priority in the triage queue. JC thanked the triage nurses, and they turned to address the needs of other patients.

Five hours later (at around 1:30 a.m.), JC was ushered into the examination room. Pursuant to North Memorial policy, a registered advance practice nurse (ARPN) arrived to conduct the examination. JC immediately began a vociferous litany of complaints:

“Why have I been sitting here for so long? It's been five hours!”
“My mouth is on fire! Fire! My pain is 10 out of 10!”
“Where the f*** is the doctor?”

The ARPN introduced herself and told JC that she would be treating her that evening. JC immediately insisted that she wanted to be treated by a specialist, an otolaryngologist (a physician trained in the medical and surgical management and treatment of patients with diseases and disorders of the ear, nose, throat (ENT)).

The ARPN calmly replied, “How about if I just take a look first.” The ARPN then proceeded to administer a standard mouth and throat examination based on JC’s clinical presentation. Based upon this exam, the ARPN determined that JC’s throat was slightly red. She had no other obvious symptoms.

The ARPN told JC: “It looks like you have a bit of a sore throat. You can gargle with saltwater. I can give you a prescription for something to gargle with that will make you feel better. You could even try some over-the-counter sprays or lozenges. We may have some free samples here at the hospital.”

JC responded: “I don't want a damn prescription. I want to see an ENT specialist. I want someone to look at all the burns in my mouth. I want you to call the police and report these burns.”

The ARPN calmly replied, “I am sorry. A specialist is not required here. I cannot see any burns in your mouth.”

JC jumped up, angry, and said, “If this is how this place is going to treat my burns, then forget it.” JC ran out of the examination room and left the ED and the hospital. The ARPN shook her head. Yet, she did not have time to worry about it. There were many other patients waiting.

JC later showed up at the Regions Hospital ED in Saint Paul, Minnesota. There, clinicians diagnosed her with chemical burns to the back of her throat. Regions clinicians further determined that a sort of special mustard/pepper spray had caused the injury. Over the past few months, teen gangs had been spraying such substances in the face of victims whom they mug/rob on the streets of Minneapolis. Regions clinicians determined that the burn was grave because of the likelihood of blistering and infection and because swelling could cause difficulty breathing. This is beyond the capabilities of the ED staff. So, Regions admits JC for "chemical inhalation burn" treatment. Yet, due to a medical records mix-up, JC never receives that treatment. She dies at Regions from complications from the burns.

On Wednesday, October 4, 2017, JC filed a pro se lawsuit against the ARPN, against North Memorial Hospital, and against Regions Hospital in the U.S. District Court for the District of Minnesota. The same system owns and operates both hospitals. That system has retained you to represent all three defendants. Because JC is proceeding pro se, her complaint is not a model of clarity. Yet, this court typically generously and broadly construes allegations made by pro se plaintiffs.

Draft a memo to your client assessing the strengths and weaknesses of the claims that JC has (probably) asserted.

APRN		
PTF has no private claim under EMTALA against an individual licensee.	4	
There was no violation anyway – see hospital case below.	--	--
North Memorial - Screening		
Triage is okay.	--	--
APRN was a legitimate QMP to do the screening.	2	
The screening was "standard," so it does not matter that NM missed PTF's EMC.	4	
North Memorial – Stabilization		
NM had no actual knowledge of PTF's EMC, therefore NM had no duty to stabilize it.	4	
PTF left on her own and was not transferred or discharged. NM had no ongoing EMTALA duties at this time in any case.	--	--
Regions - Screening		
There does not appear to be any screening issue.	--	--
Regions - Stabilization		
R knew of PTF's EMC, so R had a duty to stabilize it.	3	
R admitted PTF in good faith - to stabilizing her EMC.	4	
R's failure to stabilize is not a violation, because PTF was an inpatient at the time.	4	
Total	25	