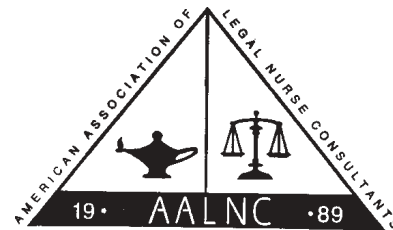


the LiNC



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A PRIVATE CAUSE OF ACTION UNDER EMTALA

By Jane Collins,
RN, BSN, JD

About the author: Jane Collins is a nurse attorney currently employed as the Risk Analyst at St. Clair Memorial Hospital in Mt. Lebanon. She earned both her B.S.N (1982) and J.D. (1992) from the University of Pittsburgh. She is currently the President of the Pittsburgh Chapter of AALNC.

INTRODUCTION

The purpose of this article is to discuss potential civil claims that may be brought by individuals based upon violations of the Emergency Medical Treatment and Labor Act (EMTALA). For the basics on this law, the reader is referred to "EMTALA: The Basics" which appeared in the fall edition of the *LiNC*.

THE ELEMENTS

Any individual who suffers personal harm as a direct result of a participating hospital's violation of EMTALA may, in a civil action against the participating hospital, obtain those damages available for personal injury and equitable relief under the law of the State in which the hospital is located. A plaintiff can file an EMTALA claim in state or federal court, but must do so within two years from the date of

the violation.

In order to prevail, the plaintiff must establish that:

- ◆ EMTALA applied;
- ◆ The hospital violated a requirement of the statute; and
- ◆ Personal injury was caused by the hospital's noncompliance.

EMTALA applies to any hospital that offers emergency services and participates in the Medicare program. In practical terms, this means that it applies to virtually every hospital in the country. Initially, EMTALA applied to individuals who presented to the emergency department requesting examination or treatment for a medical condition. This has since been expanded to include the entire hospital campus.¹

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¹ EMTALA applies to all patients, not just Medicare patients. It applies to the entire main hospital campus (sidewalks, driveways and other areas and structures within 250 yards of the main building), including ambulances, whether owned by the hospital or not. It also applies to hospital owned ambulances even if not on hospital property. If an ambulance ignores a hospital's request to divert, the ED violates EMTALA if it ignores its obligations under the statute. Recently, EMTALA has been extended to apply to outpatient departments, on or off campus.

The Baycol Recall: What You Need to Know

By Mary Janet Johnson, RN, BSN

About the author:

Mary Janet Johnson, RN, BSN is a graduate of the University of Pittsburgh School of Nursing and has 25 years of nursing experience, primarily in the cardiovascular field. She is currently employed in the Cardiac Cath Lab at St. Clair Memorial Hospital, and is in independent practice as a Legal Nurse Consultant.

On August 8, 2001, Bayer Corporation announced the withdrawal from the market of the cholesterol-lowering drug Baycol, due to reports of deaths from rhabdomyolysis, a severe adverse muscle reaction associated with the use of this drug. The recall has led to questions and government inquiries worldwide as to when Bayer first became aware of the severe side effects and fatalities associated with Baycol, and whether it failed to comply with the law in informing public health authorities of these events. Due to these deaths and subsequent questions regarding the actions of Bayer Corporation, multiple lawsuits have been filed on behalf of injured patients.

Baycol (cerivastatin sodium) is a member of the family of cholesterol-lowering drugs called statins. These drugs work to inhibit cholesterol-producing enzymes in the liver, and have been in use since 1987. They are generally considered to be effective in lowering HDL, the "bad" cholesterol, as well as triglycerides. However, all drugs in this class have been demonstrated to have the potential for serious side effects, including hematologic abnormalities, liver and renal damage, and myositis, potentially leading to severe muscle breakdown. Baycol is a relatively new addition to the market, introduced in 1997, and since statins were a well-established

class of drugs, Baycol was approved after a smaller than usual number of trials to prove its safety and efficacy. It was first approved at doses of 0.2 and 0.3mg, and Bayer achieved its market share at least in part by selling Baycol at a price significantly below that of other statins.

The first death from rhabdomyolysis associated with Baycol was reported in 1998. Rhabdomyolysis is a serious condition of skeletal muscles where cellular membranes of the muscle tissue break down, causing the release of large amounts of myoglobin and potassium into the blood. This subsequently results in overloading of the kidneys that can lead to acute renal failure. Initial symptoms include muscle pain, tenderness, fever, weakness, fatigue and dark discoloration of urine. If not quickly treated, rhabdomyolysis is a life-threatening condition. Rhabdomyolysis has been reported with all statins, and this is reflected in the corresponding prescription information for all of these drugs. It has been reported in the drug literature that an increased risk of this condition exists for patients taking statins along with gemfibrozil (Lopid), another cholesterol-lowering agent. Other drugs, such as cyclosporin, warfarin, ketoconazole, and clarithromycin may also increase the risk.

Allegations have been made against Bayer accusing the corporation of withholding information regarding adverse side effects and deaths from the public and government agencies, and at the same time maintaining a vigorous advertising campaign, and persisting in seeking approval of higher doses. The German Health Ministry has accused Bayer AG of "grave errors in its information policy" regarding the side-effects of Baycol, specifically withholding information on adverse reactions from the German institute for drugs and medical products for two months. It also has been alleged that Bayer continued to market the drug in the higher doses of 0.4 and 0.8mg daily in spite of the mounting evidence of the dose-dependent dangers of the drug. In 1999 the FDA ordered Bayer to "cease immediately" the use of one Baycol promotional sales aid for physicians that the FDA concluded was "false, lacking in fair balance, or otherwise misleading", because it implied, without substantial evidence, that Baycol was superior to other statins. The FDA also claimed that Bayer failed to present risk information "with a prominence and readability comparable to presentation of efficacy information".

In a letter to physicians on May 21, 2001 Bayer addressed

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Baycol continued from Page 2:

issues related Baycol's safety. The letter stated that a substantial number of cases of rhabdomyolysis "occurred in patients receiving Baycol in a manner inconsistent with product labeling". Specifically, Bayer reinforced the maximum starting dose of 0.4mg daily, and included a warning that a starting dose of greater than 0.4mg increased the risk of rhabdomyolysis. The letter also emphasized that treatment with concurrent gemfibrozil therapy significantly increased the risk of rhabdomyolysis. In fact in December 1999, Bayer changed the Baycol prescribing information to include a contraindication for use with gemfibrozil due to this increased risk.

On August 8, 2001, Bayer issued a statement that due to an "increased reporting rate" of rhabdomyolysis with Baycol compared to other statins at the

0.8mg dose and when used concurrently with gemfibrozil, the company was withdrawing the drug from the market. Interestingly, the recall included all countries except Japan, where it is sold only in low-dose form and the drug gemfibrozil is not available.

The consumer watchdog group Public Citizen has linked 72 fatal and 772 non-fatal cases of rhabdomyolysis to the use of all six of the statins sold between October 1997 and December 2000. The consumer group feels that the public and physicians need to be better informed about the potential for this serious complication of all statin therapy. The condition is reversible if the symptoms are reported early and the drug is discontinued promptly. The condition can be diagnosed by the blood tests CK (creatin kinase) and CPK (creatin phosphokinase), and these should be done if and muscle pain or weakness is reported.

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Physicians must also be held accountable for carefully following prescribing guidelines for all medications and being aware of potentially harmful side effects of drug therapies. When patients report symptoms of potentially life-threatening complications prompt attention and appropriate action can be critical in avoiding serious injury. As with all drug therapy, the potential risk of statins must be weighed against the benefits of cholesterol-lowering therapy. Research indicates that these drugs as a group may reduce the number of deaths from heart disease and stroke by as much as 30%.

See the following web sites for more information on the Baycol recall:

www.thebaycolrecall.com
<http://bayerpharma-na.com>

..... PITTSBURGH CHAPTER - UPCOMING EVENTS

February 13

5:00 pm Board Meeting ;
 6:30 pm Educational Meeting
Speaker: Doug Price, Esq. of Harry Cohen and Associates

Topic: Class Action Lawsuits
Location: The Law Firm of Harry Cohen & Associates, Two Chatham Center, Suite 985, Pittsburgh, PA 15219; Phone: 412 281-3000.

March 13

5:00 pm Board Meeting
 6:30 pm Educational Meeting
 Location and Topic *to be announced*

April 17-20 No Local Chapter Meeting

AALNC 2002 National Educational Conference
Title: "Fast Track to Success"
Location: Indianapolis, IN

May 8

5:00 pm Board Meeting
 6:30 pm Educational Meeting
Topic: Members who attended the National Conference review the meeting and topics
Location: to be announced

June 12

5:30 pm Current Board & Past Presidents Meeting ONLY;
Topic: A Strategic Planning Session

July Summer Break - No Meeting**August 14**

5:30 pm Dinner with Educational Meeting
Topic: Allies or Adversaries: MDs and JDs "Working Together(?)" in the Litigation Process"
Location: Rico's in the North Hills. It is less than 5 min. off 279, about 6 miles from downtown.

CLINICAL POINT

About the author:

Lori Klingman holds an ADN from Clarion University, a BSN from Pennsylvania State University and a Masters in Nursing from LaRoche College. She has had articles published in The American Journal of Nursing and an independent research project in Heart and Lung. She has also published a chapter in a Medical-Surgical text and most recently a chapter in a Nursing Care Plan book. She has taught in several schools of nursing for 16+ years. Presently, Lori is under contract with Ohio Valley Hospital School of Nursing as a clinical instructor and also has been employed by UPMC Passavant Hospital for 20 years.

Perspective of Testicular Cancer

by Lori Klingman, MSN, RN

Testicular cancer accounts for approximately 1% of cancer found in males. The incidence of cancer of the testis peaks between ages 15 and 40 years. The known risk factors include a family history of testicular cancer, a cryptorchid testis (undescended), and estrogen exposure. The increased incidence of cryptorchidism has been linked to the maternal exposure to diethylstilbestrol (DES) and oral contraceptives during pregnancy, as well as low birth weight and prematurity.

The diagnosis of testicular cancer is most often prompted by the discovery of a mass or lump on the testis along with painless enlargement of the hemiscrotum. Some men may also describe heaviness in the scrotum, inguinal area, or lower abdomen, whereas others may complain of backache, abdominal pain, weight loss, generalized weakness, or a neck mass.

If the physical examination confirms a testicular mass, the health care provider should request several laboratory and radiographic tests to distinguish a malignant tumor from a benign scrotal mass. Testicular ultrasound is usually the first diagnostic study performed. If the mass is presumed to be cancerous, chest X-rays are performed to identify pulmonary metastasis. CT scans are used to identify metastasis to the retroperitoneal lymph nodes. Liver, brain, and bone scans are also performed if there is clinical evidence of metastasis.

Blood is also drawn to

measure tumor markers, which are substances, produced and secreted by tumor cells that are found in the serum of patients. The serum tumor markers for testicular cancer are beta-human chorionic gonadotropin (beta-hCG), Alpha-fetoprotein (AFP), and lactic acid dehydrogenase (LDH). These elevated markers are used to determine when the disease is present and will return to normal when the tumor is eradicated. Therefore, these biochemical measurements aid in the diagnosis of testicular cancer, to monitor the results of treatment, and as evidence of tumor recurrence.

INTERVENTIONS

The interval between discovery of a testicular tumor and the treatment of a radical orchiectomy is often less than one week. A radical orchiectomy is generally performed as same-day surgery with an overnight hospital stay. This is a relatively short and uncomplicated procedure accomplished through an inguinal incision. Post-operatively, the surgical site is approximated with Steri-Strips or staples that remain in place 7-10 days. Upon discharge from the hospital, the patient will need to make a follow-up appointment and be instructed to contact the surgeon if he develops a fever, chills, excessive weakness, or an increase in scrotal edema.

Other treatments may include a retroperitoneal lymph node dissection. This is used for tumor staging. The patient should have a consultation with a reproductive specialist to discuss sperm banking for future fertility. Discharge instructions should include discussion of post-operative complications such as wound infection, ileus, atelectasis and pneumonia.

Other treatments may include radiation therapy and chemotherapy, also dependent on the tumor staging. Immediate treatment of low-stage testicular cancer has resulted in a 5-year survival rate of almost 95%.

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HEALTH TEACHING

Nurses possess the knowledge and skills to provide health education about testicular cancer. This includes instructing all men 15 to 40 years of age about the correct technique and time for performing *Testicular Self Examinations* (TSE). TSE is advocated as a screening technique for testicular cancer, as well as for those men who have been treated for the disease. TSE should be performed on the unaffected testis to monitor tumor recurrence.

TSE WARNING SIGNS

- ◆ A lump on the testis, often small, hard and painless
- ◆ Enlargement of the testis
- ◆ Pain in the testis
- ◆ Heaviness in the testis
- ◆ Pulling, discomfort, or pain in the lower abdomen or groin
- ◆ Breast enlargement or nipple tenderness
- ◆ Any noticeable difference in the way the testis feels from one month to another.

TSE STEPS:

TSE is best performed during a warm shower or bath while the

scrotum is relaxed and descended.

To increase sensitivity, hands should be lathered with soap.

1 Gently raise the penis upward. Observe and compare each side of the scrotum for differences in size and shape.

2 Hold the scrotum in the palm of both hands and compare the weight of each side.

3 With the thumb on top and the index and middle fingers underneath the scrotum, gently roll each testicle. Feel for lumps or areas of enlargement.

4 Locate the epididymis behind the testis. Sperm collect in this comma shaped organ that feels soft and slightly tender.

5 Move the thumb, index and middle fingers upward from the epididymis to examine the spermatic cord. This is shaped like a tube and usually feels smooth, firm, and is moveable.

*Immediate evaluation by the man's health care provider is recommended if any lumps or changes are detected by the TSE.

Given the relatively high rate of survival if testicular cancer is diagnosed early and immediately treated, the failure to make a timely diagnosis could result in

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severe, and potentially fatal, consequences to the patient. It is therefore imperative that any male patient within the high-risk age range be evaluated for the presence of testicular cancer as part of any routine physical examination.

Arguably, the failure of a health care provider to adequately assess a patient within the high-risk age range for testicular cancer and/or to instruct such patient as to the risks of testicular cancer and as to the correct techniques for performing a TSE may be incidents of medical malpractice.

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With regard to the stabilization requirement, EMTALA has been applied to inpatients, who have been admitted via the Emergency Department (ED). Depending upon the jurisdiction, it may apply to direct admits as well. It is important to note that negligence is not a required element.

There are many ways that a hospital can violate EMTALA. This article provides a brief overview of the following key theories of liability:

- Failure to provide an appropriate medical screening examination
 - Delay in performing the medical screening examination or stabilizing treatment
- Failure to stabilize the emergency medical condition
 - Failure to arrange for an appropriate transfer
 - Failure to accept an appropriate transfer.

EMTALA is a relatively new statute and the law is just developing. Therefore, the case law of other jurisdictions is discussed in order to address important principles.

It is important to note at the outset that on-call physicians, for purposes of EMTALA, represent the hospital, not their private practices. As such, they are agents of the hospital. A physician can **not** be sued individually under EMTALA². However, if a physician violates a term of the statute (e.g., fails to respond within a reasonable time³ to evaluate or stabilize an emergency medical condition), and a patient is harmed as a result, the hospital may be directly liable.

FAILURE TO PROVIDE AN APPROPRIATE MEDICAL SCREENING EXAMINATION

EMTALA requires that hospitals provide for an appropriate medical screening examination (MSE)

within the capability of the hospital's emergency department (ED), including ancillary services routinely available to the ED, to determine whether or not an emergency medical condition (EMC) exists. 42 U.S.C. 1395 dd(a) Of course, it is the plaintiff's burden to establish that the defendant failed to provide an appropriate MSE.

An appropriate medical screening examination:⁴

- Is reasonably calculated to identify an EMC suggested by the history, complaint and presenting signs and symptoms
 - Includes ancillary services routinely available to the hospital as a whole
 - Includes on-call physicians and specialists
 - Is performed by a physician or other qualified medical personnel⁵
 - Is uniform or comparable with regard to all patients who present with similar signs and symptoms, or substantially similar complaints.

A hospital fulfills its duty to screen patients in the ED if it provides a MSE reasonably calculated to identify critical medical (including psychiatric) conditions and provides a uniform level of care. *Correa v. San Francisco Hospital*, 69 F.3d 1184 (1st Cir. 1995).

The purpose of an EMTALA screening is to rule out an EMC, not to produce a definitive diagnosis. Failure to diagnose the true cause of plaintiff's symptoms, in and of itself, will not suffice as the basis for an EMTALA violation. *Eberhardt v. City of Los Angeles*, 62 F.2d 1253 (9th Cir. 1995).

To comply with the screening requirement, a hospital must provide a MSE comparable to that offered to other patients with similar symptoms. *Correa v. Hosp. San Francisco*, 69 F.3d 1184 (1st Cir. 1995). EMTALA requires only that a medical

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² Physicians may be fined (\$50,000.00/violation) or excluded from participation in the Medicare program (for repeated, gross or flagrant violations).

³ Thirty minutes in large urban areas.

⁴ Triage is not a MSE. Triage merely determines the order in which patients will be seen.

⁵ According to the Centers for Medicare and Medicaid Services (formerly the Health Care Financing Administration, a.k.a., HCFA), and the American College of Emergency Physicians, an MD should perform the screening examination. However, a NP, PA or RN (with specialized training) may be considered to be a qualified medical practitioner. The hospital must determine under what circumstances an MD is needed and when a non-physician will suffice. This must be spelled out in the medical staff bylaws, or rules and regulations, with approval by the Board of Directors.

screening procedure be established and that it be followed consistently, without regard for insurance coverage or ability to pay. In other words, the same standard of care must be applied, regardless of the patient's insurance or financial status.

EMTALA is not violated even if the screening procedure is insufficient under state malpractice law. Only disparate treatment in the screening process supports an EMTALA claim. This is consistent with the purpose of EMTALA, which is to prevent "patient dumping". The statute was not intended to serve as a federal malpractice statute. *Marshall v. East Carroll Parish Hospital Service District*, 134 F.3d 319 (5th Cir. 1998).

However, a hospital may be found to be in violation of EMTALA for failure to diagnose an EMC through an inadequate screening procedure. A MSE may be inappropriate if it is so cursory that it is not designed to identify acute and severe symptoms that alert the physician to the need for immediate medical attention to prevent serious bodily injury. *Jackson v. East Bay Hospital*, 980 F.Supp. 1341 (1997).

DELAY IN PERFORMING THE MEDICAL SCREENING EXAMINATION OR STABILIZING TREATMENT

A participating hospital may be liable for an EMTALA violation for delaying a MSE or stabilizing treatment in order to inquire about a patient's method of payment or insurance status. Similarly, a hospital may be strictly liable for delaying examination and/or treatment in order to obtain pre-authorization from the patient's primary care physician or managed care plan, even at the request of the patient. This applies equally to on-call physicians who have been enlisted to help determine whether an EMC exists or to provide stabilizing treatment.

A contract between a hospital and a managed care plan does not excuse the hospital's obligations under EMTALA. Medicare and Medicaid managed care plans are not permitted to require pre-authorization for emergency services. This is not true for private managed care plans. However, a managed care plan cannot deny a hospital permission to treat its enrollees. It may only state what it will or will not

pay for. Regardless of whether a hospital will be paid, it is obligated to provide the services specified in the statute.

FAILURE TO STABILIZE THE EMERGENCY MEDICAL CONDITION (EMC)

If any individual comes to a hospital and the hospital determines that the individual has an EMC, the hospital must provide either: further medical examination and treatment within the capabilities of the staff and facilities available at the hospital required to stabilize the medical condition, **or** transfer the individual to another medical facility. 42 U.S.C. 1395 dd (b) (1).

The hospital must provide medical treatment in order to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during transfer. 42 U.S.C. §1395dd(e)(3)(A).

It is clear that this section of the statute applies to inpatients as well as ED patients. *Roberts v. Galen of Virginia, Inc.*, 119 S.Ct. 685 (1999). Thus, if any member of the medical staff (attending or consulting physician) requests the services of the on-call physician to help stabilize an inpatient with an EMC, then the on-call MD must respond.

The hospital has no obligation to stabilize an EMC until and unless it detects it. A plaintiff must prove that the hospital had *actual knowledge* of the individual's EMC in order to establish an EMTALA violation for failure to stabilize. *Vickers v. Nash General Hospital, Inc.* 78 F.3d 139 (4th Cir. 1996).

Until recently, improper motive was considered a necessary element in an EMTALA claim based on failure to stabilize. In a unanimous per curiam opinion, the U.S. Supreme Court held that a showing of improper motive, such as lack of insurance/inability to pay, is not required to state a claim for relief under this section. *Roberts v. Galen of Virginia, Inc.*, 119 S.Ct. 685 (1999).

The determination that patients are "stable for transfer" or "stable for discharge" does not require the

final resolution of the EMC. In fact, if the hospital lacks certain capabilities and/or facilities, it may be unable to resolve the EMC.

A hospital may transfer a patient with an EMC, even if it is not stabilized, if an informed patient requests the transfer in writing or the medical benefits of transfer outweigh the increased risks. In either case, the transfer must comply with the transfer requirements set forth in the statute, as described below.

FAILURE TO ARRANGE FOR AN APPROPRIATE TRANSFER

Transfer means the movement of an individual off of the hospital campus, including an off-site testing/diagnostic facility or a physician's office. The discharge of a patient from the ED is considered a transfer, as is the discharge of an inpatient who was admitted via the ED. Depending upon the jurisdiction, discharge of direct admits may also be considered transfers.

An appropriate transfer is a transfer in which:

- The transferring hospital provides stabilizing treatment within its capabilities prior to transfer to minimize the risks
- The risks of transfer are outweighed by the benefits (this certification must be in writing by a physician or qualified medical practitioner in consultation with a physician)
- The transferring hospital provides copies of medical records available at the time of transfer related to the emergency condition for which the individual has presented
- The transfer is effected through qualified personnel and transportation equipment, including medically appropriate life support measure
- The receiving hospital has been contacted, has available space and qualified personnel, and has agreed to accept transfer of the individual.

If a patient requests the transfer, it must be done in writing. In addition, the hospital is obligated to inform the patient of its obligations under EMTALA and inform the patient of the risks of transfer. Failure to do so, would be a violation of the statute.

FAILURE TO ACCEPT A TRANSFER

A participating hospital that has specialized capabilities or facilities, or serves as the regional referral site for rural areas, may not refuse to accept an appropriate transfer of an individual who requires such specialized capabilities or facilities if the hospital has the capacity to treat the individual. *42 U.S.C. 1395 dd (g)*

In order to succeed here, the plaintiff would need to establish:

- The patient had an emergency medical condition;
- The individual required treatment beyond the capabilities or facilities of the transferring hospital;
- The receiving hospital had the specialized capabilities and facilities necessary to provide stabilizing treatment;
- The receiving hospital had the capacity to treat the patient (including an available bed and staff to care for the patient); and
- The hospital refused to accept the patient.

A hospital with specialized capabilities or facilities cannot refuse to accept a patient based on whether it has a contract with the patient's managed care plan, nor can it delay acceptance in order to obtain pre-authorization.

CONCLUSION

This article provides a brief overview of the key theories of liability available for a plaintiff who is interested in pursuing a potential claim for an EMTALA violation. Of course, this article is not a substitute for the legal research that would be necessary in order to consider bringing such a claim.

In addition to the traditional research methodologies, the following on-line resources are available:

www.medlaw.com
www.haponline.org
www.hcfa.gov
www.dhhs.gov
www.emtala.com
www.acep.org

Cultivating Your Business!

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By Doreen Wise, RN, EdD

About the Author: Doreen Wise is the founder & owner of Medicare Research Consultants, Houston, TX. Prior to becoming a LNC, she was in private practice as a nurse psychotherapist. She served as the President of our National AALNC in 1994 -95.

There are numerous and helpful technical publications on starting, structuring, and maintaining a business. Those who succeed in business discover there is more to it than just doing what is technically correct. Those interested in making the commitment to an entrepreneurial path are well advised to embrace a mainstream approach to business infrastructure ... And then there may be more you can do...

When I was in private practice as a psychotherapist I approached my staid, conservative psychoanalyst mentor about how to grow my practice. He asked what I'd already tried. I reassured him that I'd become credentialed in my chosen field, had created a professional yet welcoming work space, and had assertively requested client referrals from colleagues. I was doing educational speaking to public and professional groups, had developed a subdued but descriptive brochure and engaged a nurse-owned 24-hour answering service. My mentor absently waved these efforts aside as correct, but elementary.

"And do you really want to be a therapist?" he queried.

"Well, uh, yes, of course. Why else would I be generating so much activity?" I was perplexed.

My mentor smiled knowingly at my childlike, defensive response. "And how many patients do you want to see each week?"

"Well, it's a funny coincidence you should ask. I seem to be hovering around 13 to 14 patients a week. I think I want 20," [a full-time therapeutic load].

My teacher nodded sagely. "If you really want 20, and intend to serve them fully, then 20 patients you shall indeed have!"

I had begun to feel like Alice talking to the caterpillar in Wonderland. What mumbo-jumbo was this clinically adroit, professionally renowned physician offering? I decided to move to more recognizable terrain.

"Well, what do I have to DO?," I whined.

"You just have to want it." End of advice.

Despite the abstract sound of this dialogue, it seems that my mentor's advice did, in fact, predict my actual experience. There is a more subjective quality to business that runs parallel with the technical aspect. It takes time to become a believer; but if you will suspend disbelief momentarily, there are a few metaphysical principles to so-called success that may serve your business well too.

Growth Principle One: Decide and commit to what you intend to have.

In response to the consultation described above, I simply followed the psychoanalyst's advice. I cleared 20 places in my weekly calendar allowing room for each client. I wrote positive affirmations on cards, taking them everywhere with me: "Twenty clients weekly, and serving them fully, is how I conduct my practice." "I am a caring, successful therapist," and so on. I literally "became" the full-time, successful therapist I had envisioned.

And, of course, simple-minded as it sounds, I soon actually saw 20 patients weekly. And so it

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stayed throughout the course of my practice, hardly varying for years.

Medical legal consulting is a perfect arena for this strategy. Determine to be uniquely successful in the field, translating your intention into observable steps. Examples of affirmations might be “I am a well-respected LNC with 25 paid hours of consultation weekly.” “Lawyers count on me to get the job done well, “ etc. Probably this principle articulates with what is traditionally known as a business plan!

Growth Principle Two: You have to give business away to get it.

Taking the risk of referring overflow business on to a colleague is a smart thing to do. When you have a conflict of interest, it is the right thing to do. Not only do you avoid the conflict pitfall, but you engender credibility with your client who will be back with another case soon. You also dazzle and bemuse your LNC colleague, generating goodwill and a happy sense of obligation. That potential competitor looks for ways to give you something back, perhaps a case that she knows *you* could do better than she can.

This strategy takes courage when you are hungry for business. Keeping cases at times when you feel overextended or in which you have a conflict of interest, or could even be *perceived* as having a conflict, is tempting. And treacherous. And so, we come to:

Growth Principle Three: Stay on the moral high road.

Legal Nurse Consultants swim with sharks. Medical litigation is characterized by human misery and high stakes claims for more money than most of us make in a lifetime. The unremitting pressure to come up with the opinion that will win the case is sometimes shocking for even experienced LNC'S. All of us nurses, after all, were trained to be helpful in the extreme.

Paradoxically, the most helpful thing to do is to tell the truth whether it's the “winning opinion” or not. When I started Medical Research Consultants I remember wondering out loud “Do you suppose you can make any money telling the truth??!” It was a scary feeling, knowing ethical practice was my only choice and also knowing my household was entirely dependent on my earnings.

Our clients have come to trust that we *are* very helpful, *and* we do tell them the truth as we know it. We expect the same of our colleagues who consult or give expert testimony. In my opinion, the truly winning success strategy is to practice making everything you do, say or write, the truth. Then notice how successful you become. And, how well you sleep at night.

Growth Principle Four: Keep the patient at the focus of your practice. (Thanks to LNC Connie Sunday for this principle.)

This correlates to Principle Three and may sound like we all have to advocate for the plaintiff. What it truly means is that as nurses we bring to the litigative process the refreshing perspective of patient-centeredness. When a patient is done harm through the negligent acts of a health professional, keeping the patient as the focus necessitates supporting an appropriate settlement. When ill patients come to a plaintiff's firm seeking respite, referral to ethical, competent health care professionals for examination or treatment supersedes finding testifying doctors who have that “winning” opinion. Insisting on keeping the patient as your focus convinces your attorney clients that you *are* the competent, ethical, professional with whom they want to spend their money.

Growth Principle Five: It's okay for helping professionals to make money.

In his primer *Growing A Business*, Paul Hawken refers to some successful business owners whose philosophy is in essence “Work hard. Do

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outstanding work. Make a lot of money. Give a lot of money away! “Many of us who came of age in the sixties eschewed capitalism and all of its perils. Now that our faces have wrinkled and real life has had its way with us, some have developed a new approach.

Service well rendered is worthy of recompense. There is no shame in being well paid; one should expect it. What you decide to do with your money once you make it is up to you and will be the ultimate expression of your values. Many of us *do* “give it away” in a manner of speaking ... paying clinical colleagues in keeping with their expertise rather than what you can “get by with,” ensuring that competent, loyal employees are also paid well, and creating money for your community.

Overcoming the portion of our nursing heritage built on an oath of poverty is essential to *allowing* your business to grow. The handicapping belief that if one truly serves, one must do so for poverty wages can pervade and undermine your approach to business. In my opinion, we should school ourselves on successful money management, ever watchful of the finances. Any business consultant will tell you that even apparently successful businesses regularly fail if they do not develop financial strategies for growth.

Growth Principle Six: Always remember, “It’s only a lawsuit.” [or its Texas translation “It ain’t personal ma’am. It’s just bidness. “] Nurses *know* what real emergencies are, and lawsuits *never* are confused with them. In our office we each have a personal standard by which we evaluate any attorney client’s purported emergency. For example, my real emergency was a suicidal/homicidal patient, a known skilled marksman, who was loose on the freeway *with a car* full of guns. Yours might be the quadruple bypass surgery patient who came to you in Recovery bleeding non-stop, despite all medical efforts. Now, consider your frantic attorney

client’s statute that runs next week in reference to your personal panic standard. Usually, the attorney’s disaster looks much more manageable.

Keeping your calm when those around you are pressed by the exigencies of litigation gives you a much better opportunity to help. Falling into the collective panic *never* does. Of course you want to help, to convey that you care in the way that you’ve cared for your patients. Getting swept up and away by the panic indigenous to trial preparation can be prevented, however, by mindfulness to deadlines, careful organization of work, and gentle insistence that you be privy to all aspects of the pre-trial discovery. The calming influence provided by the trained professional who recognizes a real emergency (and knows what to do about it) can not be overemphasized as a successful business strategy.

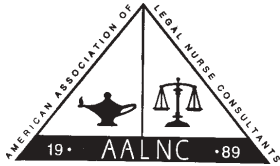
In summary, though business and the particular business of litigation are initially foreign terrain for the nurse, the LNC has all the right skills at hand to succeed. General technical business resources are essential, but true growth and success demand more unique strategies. These include: making a clear statement of business goals enables them to happen (Principle One); referring to colleagues generates new business (Principle Two); ethical business practices are essential for success (Principle Three); the wise nurse entrepreneur remembers her roots (Principle Four); service doesn’t necessarily imply poverty (Principle Five); and triage works in anybody’s disaster! (Principle Six).

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About the LiNC

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ABOUT OUR CHAPTER

Monthly Meeting Information

The Pittsburgh Chapter meets the second Wednesday of every month (except during the summer). The location of our meetings varies. Non-members are welcome to educational presentations. If you have questions about upcoming events, contact Costantini Rehab: 412.939.3426, or visit our Website: <http://www.PittsburghChapterAALNC.org>.

Educational Programming

If you have a topic that you would like to have presented at a meeting, recommendations for a speaker, a new site, or other idea for enhancing our monthly meetings, please speak with our Programming Chairperson: Joanne Boyd via e-mail @ JBoyd@dmcpc.com.

Membership Inquiries

Information about joining this organization is available through our Membership Chairperson, Patty Costantini at Costantini Rehab. Call 412.939.3426; FAX 412.939.3427.

Speaker's Bureau Inquiries

Do you need a speaker for an upcoming meeting? Ask our Speaker's Bureau Chairperson: Dana M. McDermott, BSN, RN, CNOR at: 412.279.4457; or E-mail: Danamcd12@aol.com. The Speakers Bureau is a free service to Medical-Legal Community. The Pittsburgh Chapter of AALNC provides experienced LNC's who are prepared to speak on a variety of nursing healthcare and legal topics.

Pittsburgh Chapter Business Directory

Are you seeking a nurse expert, or an LNC to consult with or to develop a case for you? You may find an LNC within our chapter who has the specific expertise you need, and who is interested in providing consultative services. Peruse our Business Directory on our Webpage. A Pittsburgh Chapter LNC may very well have the skills you need. *The Pittsburgh Chapter does not, in any way guarantee the work of the members who are listed in this directory.*