UPDATE

Hospital Violations of the Emergency Medical Treatment and Labor Act:
A Detailed Look at "Patient Dumping"

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Acknowledgement

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EXECUTIVE SUMMARY

- 264 patient dumping violations were identified involving 256 different hospitals in 41 states (Alabama, Alaska, Arizona, Arkansas, California, Colorado, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Jersey, New Mexico, New York, North Carolina, Ohio, Oklahoma, Oregon, South Carolina, Tennessee, Texas, Utah, Virginia, Washington, West Virginia, Wisconsin, Wyoming) and Puerto Rico.

- Only 26 hospitals were fined, with amounts ranging from $2,500 to $55,000 (settlements completed in 1995 and 1996, for incidents occurring between 1990 and 1995).

- Eight physicians were fined, with amounts ranging from $5,000 to $20,000 (settlements completed in 1995 and 1996, for incidents occurring between 1989 and 1994).

- More than 1 in 10 acute-care American hospitals have violated EMTALA, the federal "patient dumping" law during the law's first 10 years (September 1986 to September 1996).

- Examples of violations involving 64 patients from 31 hospitals with clinical information include:

  A 2-year-old child with a fever and history of vomiting and diarrhea earlier that day was brought to the hospital's emergency room by her mother, but instead of being medically screened, was referred to a physician's private practice. Seven hours later, the child was taken to the emergency department by ambulance, but was unresponsive, and died that evening.

  A 16-year-old patient with history of fetal alcohol syndrome and suicide attempts, was brought to the emergency room by his father who stated that the patient had threatened to kill him. The patient was allowed to be transferred by car with his father to a facility with an adolescent psychiatric unit despite the risk of the patient becoming violent and harming others.

  A 28-year-old woman went to the emergency department with severe abdominal pain. Although the medical screening exam included a positive pregnancy test, she was discharged without her severe abdominal pain being adequately investigated. Three days later, she was admitted to the hospital in shock with a ruptured ectopic pregnancy.

- Managed care members who seek emergency room care may find themselves having their treatment delayed or denied while the hospital seeks authorization for payment from their managed care organization, or may be transferred from one hospital to another in a medically unstable condition because their managed care organization has a contract with the second hospital.

- With more than 40 million people uninsured, it is not surprising that patient dumping -- occurring most commonly in patients without insurance – still goes on. Even with better reporting of violations and enforcement by the Department of Health and Human Services, ("HHS"), patient dumping will not go away until health care is recognized as a universal right.

I. Introduction

More than 10 years ago, Congress enacted a landmark piece of legislation entitled the Emergency Medical Treatment and Labor Act ("EMTALA" or "the Act").[1] The law prohibits the practice known as "patient dumping" -- hospitals denying medical screening and/or treatment to emergency patients or women in labor, often by transferring them to another hospital in an unstable condition. Patients are usually "dumped" because they are poor or uninsured, but in recent years, there have been increasing numbers of reports of patients with health insurance through health maintenance organizations ("HMOs"), or other forms of managed care, finding themselves the victims of patient dumping as well because their HMO will not authorize payment for emergency care.

Since 1991, Public Citizen's Health Research Group has published a series of reports[2] tracking the Department of Health and Human Services' ("HHS") enforcement of the Act. Using data that Public Citizen obtained from the government through Freedom of Information Act requests, the previous four reports list the names of more than 500

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[1] Section 1867 of the Social Security Act, 42 U.S.C. § 1395dd (1986). Additional requirements are included in section 1866 of the Social Security Act, 42 U.S.C. §§ 1395cc(a)(1)(I) and (N), and 1395cc(b). The Act was originally called the "Emergency Medical Treatment and Active Labor Act" but a 1989 amendment eliminated all references to the term "active" labor, which had proved difficult to define.

[2] L. Dame, S.M. Wolfe, *Patient Dumping in Hospital Emergency Rooms: An Update*, Public Citizen's Health Research Group, March 1996; J. Stieber, S.M. Wolfe, *Update on "Patient Dumping" Violations*, Public Citizen's Health Research Group, October 1994; J. Stieber, S.M. Wolfe, *Patient Dumping Continues in Hospital Emergency Rooms*, Public Citizen's Health Research Group, May 1993; J. Stieber, S.M. Wolfe, *140 Hospitals Named for Patient Dumping Violations*, Public Citizen's Health Research Group, April 1991.

hospitals found to have violated the law, or to have paid fines to settle litigation over alleged violations. This report updates the earlier reports, and, for the first time, includes an additional section where excerpts from the documents describing the patient-specific findings of government inspectors are reproduced for a number of hospitals found to have violated the Act in 1995 and 1996. (See Appendix, page 31.)

The Act requires hospitals to screen all patients seeking emergency care to determine if the patient does, in fact, have a medical emergency, and to provide whatever treatment is needed (within the hospital's capability) to stabilize the patient's emergency condition. Unstabilized patients may not be transferred to another facility unless certain criteria are met, including a doctor's written certification that the benefits of the transfer outweigh the risks.[3] Hospitals that violate the Act may be terminated from the Medicare program, and may be fined up to $50,000 for each violation. The physician responsible for examining, treating, or transferring the patient may also be fined up to $50,000 per violation, and may be excluded from Medicare for a "gross and flagrant" or repeat

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[3] Most "patient dumping" violations are based on these three core requirements. However, 1989 and 1990 amendments to the law added further provisions that occasionally serve as the basis for a violation. These include mandates that hospitals post conspicuous signs alerting patients of their right to emergency care; that they maintain lists of on-call physicians who could provide emergency treatment; and that they document all transfers of patients to or from the hospital, retaining such records for five years. A "nondiscrimination" provision prohibits hospitals with specialized facilities (such as burn, trauma, or neonatal intensive care units) from refusing to accept appropriate transfers of patients, within the hospital's capability; and hospitals may not delay emergency screening or treatment to inquire about the patient's insurance status or payment method.

violation.[4] While the law applies only to hospitals that participate in Medicare and offer emergency services, this turns out to be most of the hospitals in the country, since almost all hospitals in the United States participate in Medicare. The Act protects *all* emergency room patients seen by those hospitals, not just Medicare beneficiaries.

In spite of HHS' ability to terminate hospitals from Medicare or to fine them for violations of the Act, HHS rarely uses its sanctioning authority. From 1986, when the Act first took effect, until September 30, 1996, (the end of Fiscal Year 1996), HHS has confirmed more than 800 patient dumping violations by hospitals, but has terminated only nine hospitals from Medicare and has fined only 58 for violating the Act. This means that more than 90 percent of the hospitals that violate the law escape any penalty at all by convincing HHS that they will comply in the future. With such an extremely low chance of being penalized, hospitals have few incentives to avoid dumping patients. Indeed, in these days of cost-cutting and fierce economic competition, hospitals may find it cheaper to refuse service to an uninsured patient with a potentially expensive illness and face the consequences (or "non-consequences") of violating the law, than to meet their obligations under the Act.

In order to deter the behavior that Congress sought to prohibit in passing the Emergency Medical Treatment and Labor Act, HHS must penalize patient dumping

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[4] In addition to government enforcement, the Act allows for private lawsuits in which a patient who is harmed by a violation or a receiving hospital that suffers a financial loss as a result of an improperly transferred patient, may personally sue the offending hospital for damages. "Patient dumping" charges are often combined with medical malpractice claims in cases involving emergency services.

violations far more frequently and consistently than it has in the past. Civil monetary penalties should be assessed in many more cases to create a clear financial deterrent to patient dumping.

Although the Health Care Financing Administration, ("HCFA," the agency within HHS with the primary responsibility for enforcing the Act), has received a steadily increasing number of complaints of "patient dumping" incidents each year, the cases brought to the agency's attention clearly under-represent the frequency with which the practice still occurs. In part, this is due to the fact that for the first eight years of the law's operation, there was no reporting requirement, and HHS had to rely on voluntary complaints to bring possible cases of "patient dumping" to light. Proposed regulations published in 1988[5] included mandatory reporting provisions, which if adopted and enforced at that time, could have remedied this problem years ago. But it took HHS six years to finalize the regulations, while many hospitals continued to illegally deny care to countless numbers of patients with life-threatening emergencies. The completed rules were finally published on June 22, 1994,[6] taking effect a month later on the 22nd of July.[7] The key reporting

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[5] 53 Federal Register 22513 (June 16, 1988).

[6] 59 Federal Register 32086 (amending 42 C.F.R. Parts 488, 489 and 1003).

[7] The new regulations clarify HHS' interpretation of the Act, incorporating rulings from some of the many "patient dumping" lawsuits filed since 1986. For example, the rules make clear that the Act protects *all* persons seeking emergency services, not just those denied care because they are poor or uninsured. 59 Federal Register at 32098. The rules also spell out how the Act applies when an ambulance is diverted by radio from one hospital to another, so that the patient never physically arrives at the hospital charged with denying emergency care. 59 Federal Register at 32098. (Issue raised in *Johnson v. University of Chicago Hospitals*, 982 F.2d 230)(7th Cir. 1992)). The rules state that the Act applies to

provision, however, which requires all hospitals that participate in Medicare to notify government officials "any time [they have] reason to believe [they] may have received an individual who has been transferred in an unstable emergency medical condition from another hospital" in violation of the Act,[8] did not become effective until September 1995 -- more than seven years after it was initially proposed, and nine years after the Act was passed.[9] Hospitals that fail to report suspected violations within 72 hours can be terminated from the Medicare program. HHS states: "[T]he formal reporting procedures are an integral part of the Department's enforcement scheme to ensure that hospitals are complying with the statute. . . .We are looking to those institutions in the best position to discern when an inappropriate transfer has taken place in violation of the statute, because Congress regards them also as victims of 'dumping'."[10] It is too soon to determine whether the reporting requirement will have a large impact on the number of dumping cases reported. Vigorous enforcement of the reporting requirement by HCFA will be a key factor in whether it is effective in uncovering cases of patient dumping and ultimately helping to reduce the practice. It seems unlikely, however, that HCFA will terminate hospitals for

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psychiatric emergencies and acute alcohol and drug intoxication, which have been the subject of enforcement disputes. 59 Federal Register at 32107-32108. Finally, the rules clarify important terms in the law and explain HHS' enforcement procedures, to help hospitals better understand what is required of them.

[8] 42 C.F.R. § 489.20(m).

[9] 60 Federal Register 50443. Because the reporting provision imposes paperwork obligations on hospitals, it had to be approved by the Office of Management and Budget (OMB) before it became effective, and OMB approval took more than a year.

[10] 59 Federal Register at 32106, 32107.

failing to report a "patient dump," when HCFA is so reluctant to terminate those hospitals that actually do the dumping.

II. 256 hospitals named in Fiscal Years 1995 and 1996 for "patient dumping" violations; 26 pay monetary penalties

Public Citizen's 1991, 1993, 1994 and 1996 reports named 503 hospitals cited by HHS for 549 "patient dumping" violations from 1986 through March 31, 1995, including 41 (eight percent) that were penalized. These 41 hospitals include 32 hospitals that paid monetary penalties and nine hospitals that were terminated from Medicare. In addition, four physicians paid monetary penalties during this time period.

This report updates the series with the names of 256 hospitals in 41 states and Puerto Rico responsible for 264 patient dumping violations reported between April 1, 1995, and September 30, 1996.[11] Twenty-three of these hospitals (9 percent) were also cited for violations prior to April 1, 1995 (listed in Public Citizen's earlier reports). The report also names 26 hospitals and 8 physicians who agreed in 1995 and 1996 to pay fines to HHS in order to settle litigation over alleged violations of the Act. These alleged violations occurred between 1990 and 1995. With the addition of these 256 hospitals, it brings the total number of hospitals that have violated EMTALA during its first 10 years, (September 1986 to September 1996), to almost 700 hospitals, or more than 1 in 10 acute-care

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[11] This report is based on logs of complaints received by the Health Care Financing Administration between April 1, 1995 and September 30, 1996. It also includes fourteen cases where HCFA received the complaint before April 1, 1995, but had not completed the investigation or confirmed the violation at the time of Public Citizen's last report.

hospitals in the United States.[12]

III. HHS enforcement of the "patient dumping" law in 1995-1996

Responsibility for enforcing the federal anti-dumping law is divided between two agencies within HHS: the Health Care Financing Administration ("HCFA") and the Office of Inspector General ("OIG"). HCFA is authorized to ban hospitals from further participation in Medicare -- a serious penalty since most hospitals rely on Medicare funds for a significant part of their revenues. However this penalty is rarely used because of concern that excluding hospitals from Medicare may detrimentally affect patients' access to services in their community. A hospital will only be dropped from Medicare if it has violated the Act on one or more occasions in the past *and* fails to take "corrective action" sufficient to satisfy HCFA that no further violations will occur in the future. Such action might include changes in the hospital's policies and procedures -- for example, amending its by-laws to guarantee emergency screening and treatment, and re-training its staff to ensure that the rules are observed.

Only six hospitals have been terminated from Medicare by HCFA for "patient dumping" offenses since 1986, four of which were later recertified. An additional three hospitals voluntarily withdrew from Medicare following confirmed violations, and four others

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[12] Public Citizen's database of EMTALA violations, based on the HCFA logs, contains 692 different hospitals with confirmed violations since 1986; because we do not enter a hospital into the database if there is any ambiguity in the HCFA log, our count underestimates the number of hospitals that have violated the law. According to the *Statistical Abstract of the United States 1996*, (Table No. 187), there were 5,229 non-federal, short-term community hospitals and 696 psychiatric hospitals in the U.S. in 1994. Using these data, at least 11.6% of the hospitals in the U.S. have violated EMTALA since 1986.

closed before alleged dumping violations could be confirmed.

Table 1 lists 256 hospitals found by HCFA to have violated the law in FY1995 and FY1996, but which were *not* terminated from Medicare due to corrective action taken by the hospital. Eight were cited for more than one violation during this period, while 23 had prior offenses from 1986 through March 30, 1995. Altogether, 31 hospitals in Table 1 (12 percent) escaped Medicare termination despite more than one violation since 1986. In these cases, the hospitals' purported corrective action failed to prevent additional violations of the law.

Whether or not a hospital is terminated from Medicare participation by HCFA, it is subject to a second type of penalty by HHS. Independent of HCFA's authority to terminate hospitals from Medicare, the OIG may impose monetary fines based on its own investigation of "patient dumping" complaints.[13] Presumably, the OIG takes such action when it concludes that an egregious violation warrants a penalty despite the hospital's subsequent compliance with the law. Between 1986 and the end of 1996, 58 hospitals and 12 individual physicians have been fined amounts ranging from $1,500 to $150,000. These cases are usually resolved by settlement agreements between the OIG and the hospital or physician involved, which may take several years to negotiate. The agreements state that the hospital or doctor does not admit to having violated the law but agrees to pay

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[13] A 1990 amendment requires the OIG to consult with a peer review organization (PRO) before it may impose "patient dumping" fines. The PROs are federally-funded state-level agencies contracted by HCFA to monitor the utilization and quality of Medicare services in each state. HCFA also consults the PROs in some "patient dumping" cases to determine whether adequate medical screening or treatment occurred, except in cases where delay would jeopardize the health or safety of individuals. 42 USC § 1395dd(d)(3).

a specified sum to the government in order to avoid litigation of the case.

Prior to October 1994, only some of the dumping cases confirmed by HCFA would reach the OIG for review. Regional HCFA offices would refer some, but not all, dumping cases to OIG field offices, where the case might be closed or sent on to OIG headquarters in Washington, D.C. This less-than-seamless system resulted in only a small number of cases where hospitals were fined for their dumping violations. Beginning in October 1994, the policy was changed, and now HCFA regional offices send all cases of confirmed dumping violations to the OIG Office of Civil Fraud and Administrative Adjudication in Washington, D.C. This centralized review may reduce regional disparities in enforcement, at least in relation to monetary penalties, and may increase the coordination of enforcement between the OIG and HCFA.

While it is too soon to discern a pattern, there appears to have been a significant increase in the number of settlements concluded in 1994, 1995 and 1996, compared to earlier years. As illustrated in Figure 1, (page 29), 36 of the total 58 settlement agreements in which hospitals paid monetary fines to resolve alleged patient dumping violations, have occurred in the past three years. In spite of this upward trend, the absolute number of fines paid by hospitals remains far too low, given the number and serious nature of many of the violations.

Table 2 shows the 26 settlements between hospitals and the OIG completed in 1995 and 1996, for amounts ranging from $2,500 to $55,000. All but one of the 26 agreements include "community outreach" provisions, describing steps the hospital promises to take to publicize its availability to treat emergency patients, regardless of their

ability to pay.[14] Table 3 shows the eight settlements between individual physicians and the OIG completed in 1995 and 1996, for amounts ranging from $5,000 to $20,000.

IV. Patient Dumping and Managed Care

When EMTALA was enacted in 1986, it was in response to episodes where hospital emergency rooms denied care or transferred medically unstable patients to other hospitals mainly because the patients were uninsured and could not pay for care. While the law covers all patients, not merely the uninsured, the primary concern was about patients who would be treated in a medically unsound manner due to economic considerations by the hospital. Since hospitals had no financial incentive to refuse to treat or to inappropriately transfer insured patients, the law's focus was on the uninsured, or those insured through Medicaid or other public aid programs.

In the last five years, however, dramatic changes in the American health care system have altered the economic considerations hospitals face. Today, the majority of insured Americans are insured through some sort of managed care plan,[15] (including health maintenance organizations or "HMOs"), and the rules and payment schemes of these

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[14] Only one of the pre-1993 settlements included community outreach provisions. In fact, 10 of the 17 settlements signed from 1986 through 1992 included confidentiality clauses, in which the OIG agreed not to affirmatively publicize the case. This policy was discontinued in 1992, and none of the settlements since 1993 promise secrecy. Current OIG policy is to include a community outreach provision in all settlements with hospitals, where the hospital must publish a notice in a local newspaper explaining that its emergency department is open to all members of the community.

[15] Most insured Americans get their health insurance through employment-based insurance, where managed care is the dominant form of coverage. In 1997, managed care made up 81% of enrollment nationwide, compared with 29% in 1988. *Medical Benefits*, Vol. 14, No. 13, July 15, 1997 (from KPMG Peat Marwick LLP, 6/18/97).

plans conflict with the requirements of EMTALA. Managed care organizations attempt to control costs by directing patients to the least expensive location for treatment, and by requiring expensive tests, procedures, and treatments to be "pre-authorized." In particular, managed care organizations attempt to discourage the use of hospital emergency rooms, or try to direct their members to those hospitals with which the managed care organization has a contract. These cost control techniques do not mesh well, however, with the needs of emergency medicine, where injured, sick, and hurting patients often need care quickly, during "non-business hours," and without complicated authorization roadblocks.

EMTALA prohibits hospital emergency rooms from delaying treatment to inquire about insurance or payment, and requires the hospital to medically screen all patients who come to the emergency room seeking care, and, if an emergency medical condition exists, to stabilize the patient before transferring them, unless the benefits of the transfer outweigh the risks. Yet managed care members may find themselves having their treatment delayed while the hospital seeks authorization for payment from their managed care organization, having their treatment denied if authorization is refused, or being transferred from one hospital to another in an unstable condition because their HMO has a contract with the second hospital.

Like the economically-motivated "patient dumping" of uninsured patients that prompted the passage of the law, the inappropriate delay or denial of treatment, or transfer of medically unstable HMO patients is likewise occurring for economic, not medical, reasons and can result in harm to patients needing emergency medical care. When a managed care organization refuses to authorize payment for the emergency room

treatment of one of its members, the hospital is still obligated to meet the requirements of EMTALA -- that is, to medically screen the patient, and stabilize any emergency conditions. A hospital cannot use the fact that the HMO denied authorization as a reason to refuse to treat the patient. Examples of some of the kinds of EMTALA violations that have occurred because of the conflicts between managed care and emergency room medicine can be found in cases reported in the Appendix to this report. We have designated four cases in particular as exemplifying emergency room/managed care problems, and have labeled them in the Appendix with "Managed Care Issues."

V. Universal coverage key to ending "patient dumping"

In spite of the fact that it has been against the law for more than 10 years to "dump" a patient, the ever-increasing numbers of EMTALA violations each year demonstrate that it is still a concern. To deal with this problem, the government must step up its enforcement of the Act, and especially should seek to impose monetary penalties in many more cases. In addition, as the government's experience with enforcing the Act grows, and more data on the various hospitals involved in violations are available, the government should incorporate a centralized review of the violation history of hospitals to ensure that those hospitals with recurring violations are dealt with in a firmer manner than is now the case.

However, government vigilance alone will not end "patient dumping" as long as more than 40 million people remain uninsured and clinical decisions are driven by concerns about who pays the bills. The recent problems that patients insured through managed care

organizations have had in emergency rooms have emphasized how economic, rather than medical, considerations are still playing a major role in many emergency room decisions. Patients in life-threatening condition will continue to be denied care until access to health care is recognized and provided as a basic right. Patient dumping from American hospital emergency rooms is a dangerous, disgraceful but predictable accompaniment to the market-driven health care system in the richest nation in the world. True health care reform -- including universal coverage -- is needed to put a stop to this unconscionable and deadly practice.

Sources of Data in Table 1

- The data in Table 1 are taken from logs of patient dumping investigations conducted by the Health Care Financing Administration ("HCFA"), which were obtained by Public Citizen under the Freedom of Information Act (5 U.S.C. § 552). These logs are compiled annually by the Central Office of HCFA's Health Standards and Quality Bureau, based on information submitted by its 10 regional offices.

- The data in Table 1 concerning some hospitals are also based on copies of HCFA letters of notification and copies of Statements of Deficiencies (Form 2567), which were obtained by Public Citizen under the Freedom of Information Act, for a sample of hospitals in all regions.

- The tax status of the hospitals, (for-profit or not-for-profit), was obtained from information in *The AHA Guide to the Health Care Field*, 1995/6 and 1996/7.

- The violations listed in Table 1 are those complaints that were received by the regional offices between April 1, 1995 and September 30, 1996, and were confirmed as violations of the law by the regional office (either during that period or later). Table 1 also includes 14 violations that were reported to the regional offices *before* April 1, 1995, but had not been confirmed as violations by the time of Public Citizen's Health Research Group's last report (March 1996). Finally, there are a number of complaints that were received by the regional offices during the time period covered by this report, but which are not included, either because the investigations are still pending, or because incomplete logs from some regions made it impossible for Public Citizen to confirm the violation. These violations will be included in the next Public Citizen report.

Table 1

Hospitals Found In Violation of Patient Dumping Law

But Not Terminated From Medicare due to Corrective Action Taken By Hospital

(Complaints Received by HCFA between 4/1/95 9/30/96)

State	*Hospital* (* = cited for additional violation in prior year)	*City*	*Provision(s) Violated*	*Date Violation Confirmed*	*Status*	
Alabama	Baptist Medical Ctr.	Birmingham	TX	11/17/94	N	
	Crenshaw Memorial	Luverne	TX,SC	12/2/94	N	
	Medical Center East	Birmingham	TX	4/17/96	N	
Alaska	South Peninsula Hospital	Homer	SC,TR	4/5/96	N	
Arizona	Kingman Regional Med. Ctr.	Kingman	SC,TR	7/18/95	N	
	Southeast Arizona Med. Ctr. *	Douglas	SC,TR	6/6/95	N	
	Thunderbird Samaritan Hospital	Glendale	SC,TR	5/10/96	N	
Arkansas	Baptist Medical Center	Little Rock	SC,TR	3/1/96	N	(A)
	Conway County Hospital	Morrilton	SC	2/23/96	N	
	Crittenden Memorial Hospital	West Memphis	SC	3/13/96	N	
	Dardanelle Hospital *	Dardanelle	TR	1/22/97	N	(A)
	Drew Memorial	Monticello	SC,OC	6/29/95	N	
	Newport Hospital & Clinic	Newport	TX	1/22/97	P	(A)
	Randolph County Medical Center	Pocahontas	SC	1/25/96	P	
	Saline Memorial Hospital	Benton	SC	1/22/97	N	
	St. Vincent *	Little Rock	SC,TR	7/11/95	N	
California	Alexian Brothers Hospital	San Jose	TR,MR,SC	8/13/96	N	(A)
	Bellwood General	Bellflower	SC,TR,TX	1/25/96	P	(A)
	Central Valley General	Hanford	SC,TX,TR	7/8/96	P	
	Chowchilla Dist.	Chowchilla	TR	6/24/96	N	
	Citrus Valley Medical Center	West Covina	OC,SC	2/14/97	N	(A)
	Community & Mission Hospital	Huntington Park	SC,TR	5/24/96	P	
	Corcoran District Hospital	Corcoran	TR,SC,CL	11/26/96	N	
	Desert Valley	Victorville	TR,SC	4/3/95	P	

Provision(s) Violated:

DT	Delay in treatment (to inquire about insurance status)	**ND**	Non-Discrimination (specialized facility must accept transfer)	**SP**	Sign posting
MR	Failure to keep medical record for five years	**PP**	Failure to have policies & procedures	**TR**	Transfer
		CL	Failure to maintain central log	**OC**	On-call list
				SC	Screening
				TX	Treatment

Date Violation Confirmed:

Indicates the date upon which the Reginal Office of HCFA confirmed that the hospital had violated the law.

For-Profit/Not-For-Profit Hospitals

P = For - Profit N = Not-For-Profit U= Status Unknown

(A) = clinical information in Appendix

Sources:

Health Care Financing Administration, Log of Section 1867 Cases, Fiscal Years 1995&1996; correspondence from HCFA's Regional Offices; American Hospital Association, *The AHA Guide to the Health Care Field*, (1995/96 & 1996/97)

State	Hospital (* = cited for additional violation in prior year)	City	Provision(s) Violated	Date Violation Confirmed	Status	
California	Doctors Med. Ctr.	Modesto	TR	7/11/95	P	
	El Camino Hospital	Mount View	SC,TR		N	
	Fresno Community *	Fresno	TR,SC	9/12/95	N	
	Hanford Com. Med.Ctr. *	Hanford	TR,SC	8/8/96	N	
	John Muir Medical Center	Walnut Creek	SC,TX,TR	8/2/96	N	
	Kaweah Delta Dist.	Visalia	TR,SC	4/19/96	N	
	Memorial Hospital of Gardena	Gardena	TR,OC	8/13/96	P	
	O'Connor Hospital	San Jose	SC,TR	9/25/96	N	
	Redbud Community Hospital	Clearlake	TX,TR	7/23/96	N	(A)
	Roseville Community	Roseville	TR,SC	4/24/95	N	
	Scripps Memorial Hospital	Chula Vista	TX,SC	6/5/96	N	
	Selma District Hosp.	Selma	OC	2/1/96	N	
	Sempervirens	Cutten	SC,TX	11/6/95	U	
	Sierra Kings *	Reedley	TR,OC	11/18/95	N	
	St. Joseph's	Eureka	TR	2/7/96	N	
	Stanislaus Med. Ctr.	Modesto	TR,SC	2/27/96	N	
	Tulare District Hospital	Tulare	SC,TR	12/2/96	N	
	UC Irvine Med. Ctr.	Orange	TR,SC,DT	5/6/96	N	
	Victor Valley Community	Victorville	SC,TR	6/18/96	N	(A)
Colorado	Memorial Hospital	Craig	SC	10/8/96	N	
	North Suburban Med. Ctr.	Thorton	DT	5/9/96	P	
	St. Mary-Corwin	Pueblo	PP	9/10/96	N	
	University Hospital	Denver	PP	12/26/96	N	
Florida	AMI Palmetto General *	Hialeah	TR	7/13/95	P	
	Baptist	Miami	TX	11/17/94	N	
	Baptist Med. Ctr.	Jacksonville	TX	5/17/95	N	
	Cleveland Clinic Hospital	Ft. Lauderdale	SC,TX	4/23/97	N	
	Coral Gables	Coral Gables	TX	5/11/95	P	
	Coral Springs Med. Ctr.	Coral Springs	SC	5/4/95	N	

Provision(s) Violated:

DT	Delay in treatment (to inquire about insurance status)	**ND**	Non-Discrimination (specialized facility must accept transfer)	**SP**	Sign posting
MR	Failure to keep medical record for five years	**PP**	Failure to have policies & procedures	**TR**	Transfer
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State	Hospital (* = cited for additional violation in prior year)	City	Provision(s) Violated	Date Violation Confirmed	Status	
Florida	Coral Springs Med. Ctr.	Coral Springs	TR	3/18/96	N	
	Deering Hospital	Miami	TR	8/21/95	P	
	Emerald Coast	Apalachicola	TX	4/14/95	P	
	Fishermen's	Marathon	TX	4/3/96	P	
	Flagler Hospital-West	St. Augustine	TX	4/18/95	N	
	Florida Hospital	Kissimmee	TX	12/11/95	P	
	Ft. Walton Beach Med. Ctr.	Ft. Walton Bch	TX	7/12/95	P	
	Gadsden Memorial	Quincy	TX	5/16/95	N	
	HCA L W Blake	Bradenton	TX	5/5/95	P	
	Healthsouth Larkin	South Miami	TR	8/18/95	P	
	Mariners Hospital *	Tavernier	TX	9/8/95	N	
	Mariners Hospital	Tavernier	SP	8/21/96	N	
	Mercy Hospital	Miami	SC	8/21/95	N	
	Princeton	Orlando	TX,TR,SC	3/31/95	N	
	So. Shore Hospt. & Med. Ctr.	Miami Beach	SC,TR	2/29/96	N	
	South Florida Baptist	Plant City	SC,TR	8/8/96	N	
	Tampa General	Tampa	TX	1/26/95	N	
	Winter Park Mem. Hospital	Winter Park	TR	3/7/95	N	
Georgia	Berrien County Hospital	Nashville	TX	4/19/96	P	
	Clinch Memorial Hospital *	Homerville	TX	3/4/96	N	
	Emanuel County Hospital	Swainsboro	SC	4/9/96	N	
	Meadows Regional Med. Ctr.	Vidalia	SC	4/19/96	N	
	Meriwether Regional Hospital	Warm Springs	SC	3/4/96	N	
	Screven County Hospital	Sylvania	SC	5/7/96	N	(A)
	Southwest GA Regional Med. Ctr	Cuthbert	SC,TX,TR	11/14/96	N	(A)
Hawaii	Kapiolani Hospital	Honolulu	SC	8/1/95	N	
Idaho	Silver Valley Med. Ctr.	Silverton	TR	7/5/96	U	

Provision(s) Violated:

DT	Delay in treatment (to inquire about insurance status)	**ND**	Non-Discrimination (specialized facility must accept transfer)	**SP**	Sign posting
MR	Failure to keep medical record for five years	**PP**	Failure to have policies & procedures	**TR**	Transfer
		CL	Failure to maintain central log	**OC**	On-call list
				SC	Screening
				TX	Treatment

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Illinois	Blessing Hospital	Quincy	SC	2/21/96	N	
	Doctors Hospital of Hyde Park *	Chicago	SC		P	(A)
	Evanston Hospital	Evanston	TR	2/20/96	N	
	Glenbrook/Evanston	Glenview	SC	12/15/95	N	
	Lutheran General	Park Ridge	SC,TX	11/8/95	N	
	Methodist Hospital	Chicago	SC,TX	7/18/95	N	
	Norwegian American Hospital	Chicago	SC,TX	8/16/95	N	
	Perry Memorial	Princeton	SC,TX	12/7/95	N	
	South Shore Hospital *	Chicago	SC	6/11/96	N	
	St. Bernard *	Chicago	SC	10/20/95	N	
	St. Cabrini	Chicago	SC	8/31/95	N	
	St. Cabrini	Chicago	TR	4/20/95	N	
	St. Elizabeth's Hospital	Belleville	SC,TR	11/7/96	N	
	St. Joseph	Chicago	SC	9/5/95	N	
	St. Joseph Med. Ctr.	Joliet	TR	7/17/95	N	
	Vencor Hospital Chicago North	Chicago	SC,TX,TR	9/3/96	P	
Indiana	CPC Valle Vista	Greenwood	SC	4/28/95	P	
Iowa	Jackson Co. Public Hospital	Maquoketa	TR	1/15/96	N	
	Marshalltown Med. & Surgical	Marshalltown	SC	1/12/96	N	
	Marshalltown Med. & Surgical	Marshalltown	TR	3/26/96	N	
	Mercy	Corning	SC	5/18/95	N	
	Mercy Hospital	Council Bluffs	TR	6/6/96	N	
	Muscatine General	Muscatine	TR	5/18/95	N	
	Samaritan Health System	Clinton	TX	10/25/95	N	
	St. Anthony's Regional	Carroll	TR	2/27/96	N	
Kansas	Bethany Medical Center	Kansas City	SC	3/26/96	N	
	Charter Hospital	Overland Park	TR	2/14/96	U	
	Jefferson County Memorial *	Winchester	TR,SC	8/20/96	N	

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Kentucky	Casey County Hospital	Liberty	SC,TR	9/17/96	U	
	McLean County General Hospital*	Calhoun	SC	8/22/96	N	
	Middleboro ARH	Middleboro	TX	5/1/95	N	
	Nicholas County Hospital	Carlisle	SC	5/30/96	N	
	Paul B. Hall Reg. Med. Ctr.	Paintsville	TX	6/1/95	P	
	Westlake Cumberland Hospital	Columbia	SC,TR	7/18/96	N	
Louisiana	Greenbriar Hospital	Covington	SC,TX,TR	1/23/96	P	
	Medical Center of Louisiana	New Orleans	ND	5/3/96	N	
	Minden Medical Center	Minden	SC,TX,TR	1/25/96	P	(A)
	River North	Pineville	ND	10/19/95	P	
	Springhill Medical Center	Springhill	SC,DT,CL	11/4/96	P	(A)
Maine	Houlton Regional Hospital	Houlton	TR	4/29/96	N	
	Inland Hospital	Waterville	OC	5/6/96	N	
	Mayo Regional Hospital	Dover-Foxcroft	TR	8/2/96	N	
	Redington-Fairview General	Skowhegan	TR	5/30/96	N	(A)
Maryland	Anne Arundel Medical Center	Annapolis	TR,SC	6/13/96	N	
	Atlantic General	Berlin	SC	6/8/95	N	
	Carroll Co. Gen. Hosp.	Westminster	SC,SP	10/17/95	N	
	Dorchester General Hospital	Cambridge	SC,SP	8/15/96	N	
	Good Samaritan	Baltimore	SC	12/4/95	N	
	Kent and Queen Anne's Hospt.	Chestertown	SC,TR	12/3/96	N	
	Peninsula Regional Medical Ctr *	Salisbury	SC	10/11/96	N	
	Washington County	Hagerstown	SC,SP	8/31/95	N	
Massachusetts	Deaconess-Nashoba Hospital	Ayer	SC	7/2/96	N	
	Deaconess-Waltham Hospital	Waltham	SC	7/18/96	N	
	Harrington Memorial Hospital	Southbridge	SC,TR	7/22/96	N	(A)
	Lawrence General	Lawrence	SC	9/3/96	N	
Minnesota	Mahnomen County & Village	Mahnomen	TX	9/2/95	N	

Provision(s) Violated:

DT	Delay in treatment (to inquire about insurance status)	**ND**	Non-Discrimination (specialized facility must accept transfer)	**SP**	Sign posting
				TR	Transfer
MR	Failure to keep medical record for five years	**PP**	Failure to have policies & procedures	**OC**	On-call list
		CL	Failure to maintain central log	**SC**	Screening
				TX	Treatment

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Mississippi	Baptist Memorial	Booneville	SC	3/4/96	N	
	Baptist Memorial	Booneville	SC,TX	9/6/95	N	
	Hardy Wilson Memorial	Hazlehurst	SP	1/24/96	N	
	Hardy Wilson Memorial	Hazlehurst	TX	6/26/95	N	
	Montfort Jones Memorial	Kosciusko	SC	10/24/96	N	
Missouri	Alexian Brothers Hospital	St. Louis	SC	1/25/96	N	
	Barnes-Jewish St. Peters	St. Peters	TR	7/12/96	N	
	Breech Medical Center *	Lebanon	SC	1/12/96	N	
	Doctors Hospital	Springfield	TR	1/11/96	P	
	Hannibal Regional Hospital	Hannibal	SC	7/8/96	N	
	Missouri Delta Medical Center *	Sikeston	TX	7/30/96	N	(A)
	Phelps County Regional Med Ct	Rolla	SP	7/16/96	N	
	Ripley County Memorial Hospt.	Doniphan	SC	3/7/97	N	(A)
Montana	Broadwater Health Center	Townsend	SC	2/27/96	N	
	Livingston Memorial	Livingston	SC	5/24/96	N	(A)
	Mineral Community	Superior	TR,SC,SP	6/13/96	N	
	Missouri River Med. Ctr.	Fort Benton	TR	5/24/96	N	
	Mountainview Memorial	White Sulphur	SC	3/19/96	N	
	Phillips County Hospital	Malta	SC	5/22/96	N	
	St. James Community	Butte	TX	6/30/95	N	
	St. John's Lutheran	Libby	SC	10/7/96	N	
	St. Peter's	Helena	SC,DT,OC	3/19/96	N	
	Teton Medical Center	Choteau	TX,TR	3/19/96	N	
Nebraska	Lincoln General	Lincoln	TX	2/12/96	N	
Nevada	Desert Springs Hospital	Las Vegas	TR	5/10/96	P	
New Jersey	Carrier Clinic	Belle Mead	SC	5/25/95	N	
	East Orange General	East Orange	SC	12/30/96	N	

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New Jersey	Hunterdon Medical Center	Flemington	SC	3/5/96	N	
	Jersey City Medical Center	Jersey City	TR	8/13/96	N	
	Mercer Medical Center	Trenton	SC	3/7/96	N	
	Monmouth Medical Center	Long Branch	SC	2/29/96	N	
	Muhlenberg Reg. Med. Ctr.	Plainfield	SC	9/25/95	N	
	Riverview Medical Center	Red Bank	SC	4/10/96	N	
	St. James	Newark	SC	1/24/97	N	
	St. Mary's Hospital	Hoboken	SC	6/13/96	N	
	Underwood Memorial	Woodbury	TR	1/27/97	N	
	United Hospital *	Newark	SC	9/25/95	N	
New Mexico	Mimbres Memorial Hospital	Deming	SC,OC,SP	3/14/96	N	(A)
New York	Adirondack Medical Center	Saranac Lake	TR	8/13/96	N	
	Bertrand Chaffee Hospital	Springville	TR	6/17/96	N	
	Brooks Memorial Hospital	Dunkirk	SC	9/11/96	N	
	Chenango Memorial Hospital	Norwich	SC	4/15/96	N	
	Children's Hospital	Buffalo	DT	9/25/95	N	
	Crouse-Irving	Syracuse	DT	8/3/95	N	
	Erie County Medical Center *	Buffalo	TR	7/29/96	N	(A)
	Hepburn Medical Center	Ogdensburg	TR	8/7/96	N	
	Jamaica	Jamaica	DT	11/28/95	N	
	Kenmore Mercy Hospital	Kenmore	SC	9/5/96	N	
	Lake Shore Hospital	Irving	SC	3/7/96	N	(A)
	Lockport Memorial Hospital	Lockport	TR	5/23/96	N	(A)
	Lockport Memorial Hospital	Lockport	SC	11/6/96	N	(A)
	Medina Memorial Hospital	Medina	TR	5/31/96	N	(A)
	Millard Fillmore Hospital	Buffalo	TR	10/7/96	N	
	Mount St. Mary's Hospital	Lewiston	SC	8/5/96	N	(A)
	New York Hospital	New York	DT,TR	3/26/96	N	
	Niagara Falls Memorial	Niagara Falls	TR	6/3/96	N	

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New York	Rome Memorial Hospital	Rome	TR	5/16/96	N	
	Samaritan Med. Ctr.	Watertown	TR	9/12/95	N	
	St. Joseph's	Syracuse	TR	7/25/95	N	
	St. Luke's	Newburgh	SC,TR	5/5/97	N	
	St. Mary's Hospital	Amsterdam	SC	8/12/96	N	
	Westfield Memorial	Westfield	TR	7/18/96	N	
North Carolina	Brunswick Hospital	Supply	SC,TR	7/18/96	P	(A)
	Columbus County Hospital	Whiteville	SC	7/23/96	N	
	St. Luke's Hospital	Columbus	TR	5/9/96	N	
Ohio	Salem	Salem	SP	5/15/95	N	
Oklahoma	Atoka Memorial Hospital	Atoka	SC,TR	11/4/96	N	
	Baptist	Oklahoma City	ND	7/23/96	N	
	Bethany Health Center	Bethany	DT,SP	4/11/96	P	(A)
	Grove General Hospital	Grove	TR	11/19/96	N	
	Hillcrest Medical Center	Tulsa	SC, DT	11/12/96	N	(A)
	Mercy	Oklahoma City	ND	7/23/96	N	
	Shawnee Regional Hospital	Shawnee	TX,OC	7/23/96	N	
	St. Anthony Hospital	Oklahoma City	ND	7/23/96	N	
	St. Francis Hospital	Tulsa	ND	7/23/96	N	
	Stillwater Medical Center	Stillwater	TX,OC	3/28/97	N	
	University Hospital	Oklahoma City	ND,TR	7/23/96	N	
	Wagoner Community Hospital	Wagoner	TR	11/12/96	P	
Oregon	Cottage Grove Healthcare	Cottage Grove	DT	6/13/96	N	
	Douglas Community	Roseburg	SC	7/26/95	P	
	Good Samaritan	Corvallis	SC	7/27/95	N	
	McKenzie-Willamette Hospital	Springfield	SC	10/15/96	N	
	Merle West	Klamath	SC	9/14/95	N	
	North Lincoln	Lincoln City	SC	9/13/95	N	

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Oregon	Providence/Seaside Hospital	Seaside	SC,TR	2/6/96	N	
	Rogue Valley Med. Ctr.	Medford	SC,TR	9/14/95	N	
	Salem	Salem	SC	6/13/95	N	
	Silverton Hospital	Silverton	DT	11/8/95	N	
	Three Rivers Dimmick	Grants Pass	SC,DT	1/4/96	N	
Puerto Rico	San Carlos Gen. Hospital	Santurce	SC	9/21/95	P	
South Carolina	Allendale County *	Fairfax	TR	4/24/95	N	
	Byerly	Hartsville	TX	12/12/94	N	
Tennessee	Athens Community	Athens	TX	7/13/95	P	
	Ft. Sanders Sevier Med. Ctr.	Sevierville	TX	1/24/95	N	
	Memorial	Chattanooga	TX	4/6/95	N	
	St. Mary's Med. Ctr.	Knoxville	TR	4/18/96	N	
	Vanderbilt Med. Ctr.	Nashville	TX	5/12/95	N	
Texas	AMI Brownsville	Brownsville	SC	8/23/95	P	
	Columbia Fort Bend	Missouri City	SC	12/10/96	P	
	De Leon Hospital	De Leon	TX,TR	6/5/96	N	(A)
	Harris Methodist Fort Worth	Forth Worth	TX	8/26/96	N	(A)
	Martin County Hospital	Stanton	SC,OC	10/28/96	N	(A)
	Methodist	Lubbock	SC	2/27/97	N	
	Parkland Memorial Hospital	Dallas	SC	5/21/96	U	
	Southwestern General Hospital	El Paso	SC,MR,CL	2/4/97	P	
Utah	Alta View	Sandy	CL	7/30/96	N	
	Tooele Valley Reg.	Tooele	OC,SC,TR	9/18/95	N	
Virginia	Augusta Medical Center	Fishersville	TX	8/14/96	N	(A)
	Charter Behavioral Health Syst	Charlottesville	SC,TR	2/26/96	P	
	Dickenson County Medical Ctr.	Clintwood	TR,CL	10/8/96	N	
	Humana – Clinch Valley	Richlands	SC,TX,TR	7/25/95	P	

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Virginia	Lonesome Pine Hospital	Big Stone Gap	SC	11/26/96	N
	Newport News General	Newport News	SC,TX,TR	10/24/95	N
	Newport News General	Newport News	DT	6/7/96	N
	Riverside Regional Med. Ctr.	Newport News	SC	12/11/96	N
	Southampton Memorial	Franklin	SC	8/8/95	N
	Southside Community	Farmville	SC	8/8/95	N
Washington	Good Samaritan Hospital	Puyallup	TX	1/4/96	N
	Grays Harbor Community	Aberdeen	SC	4/8/96	N
West Virginia	CAMC -- Gen. Division	Charleston	ND,OC	10/2/95	N
	Hampshire Memorial Hospital	Romney	SC	11/14/96	P
	HCA River Park Hospital	Huntington	SC,TR	7/3/96	P
	Jackson General Hospital	Ripley	SC	7/3/96	N
	Princeton Cõmmunity *	Princeton	ND	10/2/95	N
	Richwood Area Community *	Richwood	OC	5/31/96	N
	Welch Emergency Hospital *	Welch	TX,TR,CL	9/26/96	U
Wisconsin	Brown County Mental Health Ctr	Green Bay	SC	2/27/97	N
Wyoming	Platte County Memorial	Wheatland	SC,TR	6/19/96	N

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				TR	Transfer
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Table 2

Hospitals That Paid Fines to Settle Alleged Patient Dumping Violations
(Settlements Completed in 1995 and 1996)

State	*Hospital*	*City*	*Status P=For-Profit N=Not-for-Profit*	*Provision(s) Allegedly Violated/Year*	*Year of Settlement*	*Settlement Amount*
Alabama	Mizell Memorial Hospital	Opp	N	Screening (1993)	1996	$15,000
California	Fountain Valley Regional	Fountain Valley	P	Screening, Treatment, Transfer (1994)	1995	$10,000
	Fremont Medical Center	Yuba City	N	Screening (1991)	1995	$23,000
	Glendale Memorial Hospital	Glendale	N	Screening, Treatment, Transfer (1990)	1995	$45,000
	Greater El Monte Community	South El Monte	P	Screening, Treatment, Transfer (1994)	1996	$20,000
	Valley Presbyterian Hospital	Van Nuys	N	Non-discrimination (refusal to accept patient transfer)	1996	$40,000
Florida	Aventura Hospital & Medical Center	Miami	P	Screening, Treatment (1990)	1995	$15,000
	Columbia Blake Medical Center	Bradenton	P	Screening (1995)	1996	$55,000
	John F. Kennedy Medical Center	Atlantis	N	Screening (1995)	1996	$10,000
	Northridge Medical Center	Fort Lauderdale	P	Screening (1994)	1996	$23,500

Table 2, continued

State	*Hospital*	*City*	*Status P=For-Profit N=Not-for-Profit*	*Provision(s) Allegedly Violated/Year*	*Year of Settlement*	*Settlement Amount*
Georgia	Calhoun Memorial Hospital	Arlington	N	Screening (1992)	1996	$ 5,000
	Early Memorial Hospital	Blakely	N	Screening, Treatment, Transfer (1992)	1995	$ 5,000
Iowa	Hegg Memorial Hospital	Rock Valley	N	Screening, Treatment, Transfer (1992)	1996	$ 5,000
	Madison County Memorial	Winterset	N	Screening, Treatment (1993)	1996	$ 9,000
Kansas	Ashland District	Ashland	N	Transfer (1993)	1995	$ 5,000
Missouri	Breech Medical Center	Lebanon	N	Screening (1993)	1995	$ 2,500
New York	Canton-Potsdam	Potsdam	N	[Provision violated unavailable] (1992)	1996	$15,000
	Interfaith Medical Center	Brooklyn	N	Screening (1991)	1995	$45,000
	Massena Memorial	Massena	N	Screening, Treatment (1995)	1996	$10,000
	New York Eye & Ear Infirmary	New York	N	Screening (1992)	1996	$22,500
	Our Lady of Lourdes Memorial	Binghamton	N	Screening, Treatment, Transfer (1994)	1996	$ 5,000

Table 2, continued

State	*Hospital*	*City*	*Status P=For-Profit N=Not-for-Profit*	*Provision(s) Allegedly Violated/Year*	*Year of Settlement*	*Settlement Amount*
Tennessee	Middle Tennessee Medical Center	Murfreesboro	N	Screening, Transfer (1993)	1995	$25,000
Virginia	Clinch Valley Medical Center	Richlands	P	Screening (1995)	1996	$25,000
West Virginia	Princeton Community	Princeton	N	Screening, Transfer (1994)	1996	$15,000
	St. Joseph's	Buckhannon	N	Non-discrimination (refusal to accept patient transfer) (1995)	1996	$10,000
	Welch Emergency	Welch	U	Screening (1995)	1996	$ 5,000
TOTALS:	26 hospitals					$465,500

Source: Office of Inspector General, U.S. Department of Health and Human Services

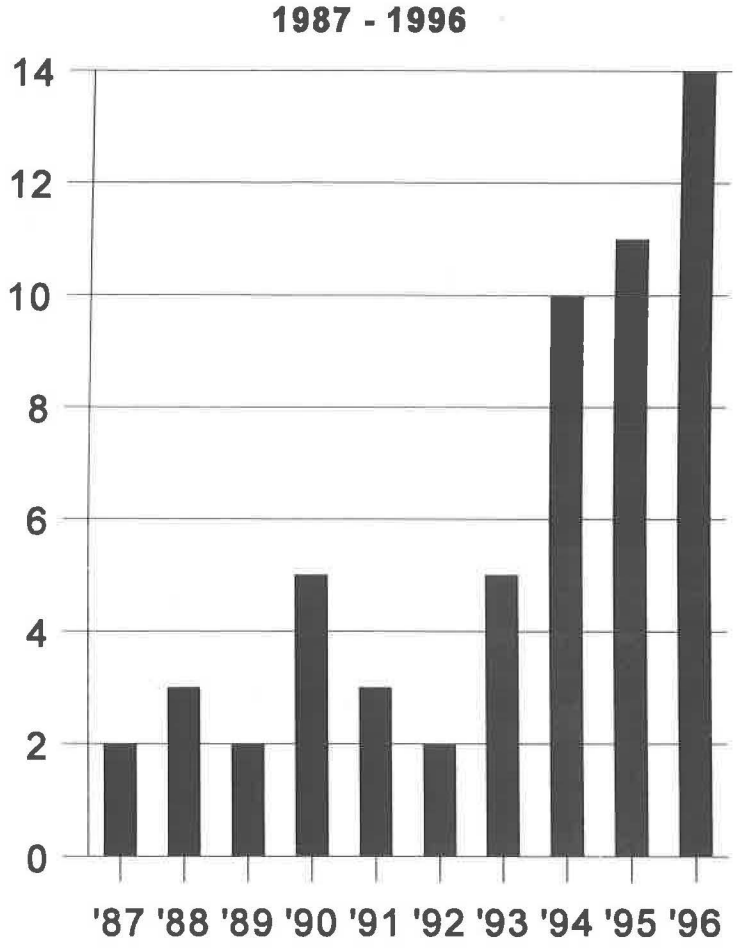
Table 3

Physicians Who Paid Fines to Settle Alleged Patient Dumping Violations
(Settlements Completed in 1995 and 1996)

State	Physician	Hospital	City	Provision(s) Allegedly Violated/Year	Year of Settlement	Settlement Amount
California	Bruce L. Hilger, MD	Fremont Medical Center	Yuba City	Screening (1991)	1996	$ 5,000
	Arnold Loo, MD	Dos Palos Hospital	Dos Palos	Transfer (1989)	1995	$15,000
Florida	Pedro Erigoyen, MD	Aventura Hospital	Miami	Screening (1990)	1995	$ 5,000
Georgia	Homer L. Lassiter, Sr., MD	Calhoun Memorial Hospital	Arlington	Screening (1992)	1995	$10,000
	Lee R. Shelton, MD	[Unavailable]	Atlanta	Screening, Treatment, (1989)	1995	$ 5,000
Massachusetts	Thomas J. Zanca, MD	Burbank Hospital	Fitchburg	Screening (1994)	1995	$15,000
Missouri	Francisco A. Gador, MD	St. Mary's Hospital	Blue Springs	Screening (1990)	1995	$15,000
New York	Jose L. Lizardi, MD	Canton-Potsdam Hospital	Potsdam	[Provision violated unavailable] (1992)	1995	$20,000
TOTALS:	8 physicians					$90,000

Source: Office of Inspector General, U.S. Department of Health and Human Services

Figure 1
Number of Monetary Settlements Between Hospitals and the OIG For Alleged EMTALA Violations



APPENDIX

Appendix

After a HCFA regional office receives a complaint of "patient dumping," it sends a team of state surveyors to investigate the case. The state surveyors examine medical and other records and conduct interviews, and submit a report to the HCFA regional office, which then determines whether the hospital violated EMTALA. When HCFA confirms a violation, it sends the hospital a notification letter and a copy of HCFA Form 2567, called a "Statement of Deficiencies and Plan of Correction," ("Deficiencies Statement"). A Deficiencies Statement is a multi-page form that contains a detailed description of the findings of the state surveyors. Each section of the form begins with the language of the relevant EMTALA regulation, and then provides the findings that are evidence that the hospital failed to satisfy that particular requirement.

Hospitals may respond to the Deficiencies Statement by providing additional evidence, which may result in the government changing its determination; with a description of the changes they have made to come into compliance with EMTALA; or they may challenge the government's findings by filing a formal appeal. Because the termination proceedings continue during the appeals process and have a shorter time frame, however, most hospitals decide to take corrective action to get back into compliance, rather than file an appeal and risk being terminated from Medicare.

Pursuant to Freedom of Information requests, Public Citizen's Health Research Group obtained copies of the notification letters and Forms 2567 (Deficiencies Statements) for *confirmed* violations in 1996, and have printed in the Appendix patient-specific

information from the Deficiencies Statements from a sample of hospitals. The Deficiencies Statements (and hospitals) chosen do not necessarily represent the "worst" violations, but rather were selected to show the variety of problems, illnesses, and types of patients involved in EMTALA cases. Each excerpt has been quoted directly from the HCFA Form 2567, with only minor changes to correct typographical or other errors. We have not reproduced the entire text of any Form 2567, since a hospital is usually cited for a variety of problems, but for each hospital appearing in the Appendix, we have excerpted the more serious problems for which that hospital was held to have violated EMTALA. In addition, we have labeled four excerpts as containing "Managed Care Issues," since these four excerpts in particular describe some of the problems managed care is creating for emergency medicine.

The purpose of providing these excerpts is to give a greater level of detail and to put human faces on the otherwise purely numerical counts of EMTALA violations and "patient dumping."

APPENDIX:
List of Hospitals with Patient-Specific Information

Excerpts from HCFA Forms 2567 -- Violations confirmed in 1995 & 1996

Baptist Medical Center
Little Rock, Arkansas

A transfer to another medical facility will be appropriate only in those cases in which the transferring hospital provides medical treatment within its capacity that minimizes the risks to the individual's health and, in the case of a woman in labor, the health of the unborn child. An inappropriate transfer was effected as evidenced by:

a.) The sending hospital personnel escorted and assisted the patient, belongings and her young child into a taxicab and instructed the taxicab driver to take the patient to the nearest Medicaid contracted hospital. No one [who was trained for medical emergencies or in the delivery of a baby] accompanied the patient. No emergency equipment or provisions were made in the taxicab for the patient should delivery be imminent.

b) There was no transfer record of notification from a Baptist Medical Center physician to the receiving hospital.

c) There was no medical record completed and sent to the receiving hospital to reflect a medical screening, treatment and stabilization along with an appropriate transfer had been effected.

Dardanelle Hospital
Dardanelle, Arkansas

The facility failed to provide for an appropriate transfer for a woman in labor in violation of 489.24(d)(2)(i-iv). The patient was experiencing contractions every four to five minutes with a duration of 30 to 50 seconds. The physician's examination revealed the cervix to be soft and dilated one fingertip. This was the patient's third pregnancy. The transfer was facilitated by private automobile with the patient's husband in attendance.

2. According to interviews with the transferring hospital personnel, there was no agreement obtained from the receiving hospital to accept the transfer.

3. The transferring hospital failed to affect an appropriate transfer through qualified personnel and transportation equipment. The patient was placed in a private automobile and instructed to go to the receiving hospital.

The transferring physician had contacted an obstetrician on the staff of the receiving hospital. The medical record which accompanied the patient did not contain: (a) documentation of the patient having been informed of the risks and/or benefits of a transfer; (b) patient status at the time of transfer.

Excerpts from HCFA Forms 2567 -- Violations confirmed in 1995 & 1996

Newport Hospital and Clinic, Inc.
Newport, Arkansas

On August 24, 1995 at 0930 [9:30 a.m.] the patient presented to the Emergency Department of Newport Hospital and Clinic, Inc. with a complaint of abdominal pain, burning when urinating starting two to three weeks ago. The information was recorded on the Emergency Department record by a Licensed Practical Nurse. Vital signs were recorded and the physician was notified at 0930 [9:30 a.m.]. A verbal order was written for a urinalysis. Documentation under "Physical Finds" on the medical record stated "Patient was informed that this would have to be cash because of Medicaid." "Patient was told that we would see her in the ER but it would be on cash basis." The patient left the Emergency Department and traveled thirty-six (36) miles to Lawrence Memorial Hospital Emergency Department. The patient was screened and transferred to St. Bernards Regional Medical Center where she underwent surgery at 1730 [5:30 p.m.] for a pre-operative diagnosis of appendicitis. The surgery lasted until 2032 [8:32 p.m.] and the post operative diagnosis was Cecal Resection and drainage of right lower quadrant abscess, ileostomy and mucosa fistula.

. . .

Based on record review the facility failed to provide sixteen (16) patients with an appropriate medical screening examination to determine whether or not an emergency medical condition existed. Fifteen (15) of sixteen (16) patients were referred to physician office without an appropriate medical screening examination and one (1) of sixteen (16) patients was asked to establish means of payment before being screened to see if an emergency condition existed.

Alexian Brothers Hospital "*Managed Care Issues*"
San Jose, California

A. Managed Care Issues:

1. Resident 1 was taken to the emergency room by her parents on 4/13/96, at 7:30 p.m., with the complaint that a dog had bitten her on the right cheek, the right eyebrow and in the right scalp. A parent in a written declaration stated, "I took my two and a half year old daughter to the emergency room to be treated for severe dog bites. We went to the front desk and said she needed a doctor to see her immediately. We were asked by the receptionist to give any insurance information while I held my daughter. A male nurse examined her bites. After receptionist and male nurse had us complete a form out, they informed us that we had to go to Kaiser for any treatment. I was afraid of going all the way to Kaiser, but they said that they could not treat her there that she needed a Plastic Surgeon. They did nothing for my daughter's wounds. I even asked for ice, they only put a gauze over the wounds."

This patient was taken to this emergency room seeking emergency medical care, she did not see a physician even briefly, nor did she receive a Medical Screening Exam (MSE). The clerk did call Kaiser, [an HMO], but it was not Kaiser Santa Clara that this family is assigned to. Thus Kaiser Santa Clara was unaware the child was being brought in with severe dog bites.

(Continued next page)

. . .

3. Patient 13 was a 13-year-old whose mother took him to the emergency room on 4/3/96 at 9:30 p.m. The nursing triage sheet documents his vital signs as "Temperature 103.6 Fahrenheit, Pulse 118. Chief complaint, fever times two weeks." Further documentation was "Dr. (managed care primary physician) denied authorization (to treat) at 9:45 p.m." Disposition not documented. This child was brought to the emergency room for emergency care of a fever of 103.6 Fahrenheit. He did not receive care nor an MSE.

. . .

7. Patient 3 presented at the emergency room on 4/13/96, asking for a medical check up. Hit in forehead by club. Managed care doctor denied authorization for medical care. "Will see patient on Monday." (Two days later). A MSE was not done.

. . .

11. Patient 23 is a 4-year-old boy brought to the emergency room on 6/20/96, with the complaint of "laceration 3-4 cm back of head." "Playing around trailer, fell over backwards striking back of head." Managed care denied authorization and patient was sent to another clinic without an MSE.

12. Patient 16 was a 14-year-old boy that came to the emergency room on 4/19/96, for medical care of lacerations of the right fourth finger, and multiple lacerations to left wrist. Authorization by Kaiser denied, sent to Kaiser, no medical screening exam.

. . .

19. Patient 26 was a 69-year-old lady that came in per ambulance, code 2, anxiety attack. Authorization denied per Kaiser [an HMO]. Daughter picked mother up. No Medical Screening Examination done.

. . .

22. Patient 29 is an 18-year-old that presented at the Emergency room on 6/11/96, at 2:40 a.m., complaining that "weight (10 lbs.) fell off roof hitting patient on top of head, has laceration on left side of head, no loss of consciousness, complains of a headache today." Authorization denied, to go to Kaiser, [an HMO], no medical screening examination done.

. . .

25. Patient 32 was a 4-year-old boy brought to the emergency room on 1/21/96, with the complaint of "running and fell, hit head against door, laceration right eyebrow, no loss of consciousness." Managed care denied authorization to treat, sent to a clinic. No medical screening exam done.

26. Patient 33 was a 27-year-old man who presented at the emergency room on 12/21/95, with the complaint of chest pain when deep breathing, fever. Managed care authorization denied, sent to a clinic. No MSE done.

(Continued next page)

27. Patient 38 was a 23-year-old woman who presented at the emergency room on 1/17/96, complaining of being "two months pregnant, blood on tissue when urinating, denies blood in urine, denies blood on pad." Kaiser [an HMO] denied authorization to treat "patient declined to pay to be seen here." No medical screening examination done.

B. Other Failures to Medically Screen:

2. Resident 12 is a 48-year-old man who went to the emergency room on 5/25/96, at 12:05 p.m. The nursing triage sheet documents chief complaint as "wants med for shaking after a fight with his brother. History of Hypertension, feels it (blood pressure) is up now." Blood pressure documented at "189/101, and pulse at 114." Nursing triage sheet documents current medication as "Procardia, Lotresin, and Diuretic PM." The nurse further documents 12:25 p.m. "patient has no insurance, when clerk asked him to make a deposit, he said he would go to VMC (Santa Clara Valley Medical Center). When I asked him to wait so I could get authorization from MD, he just left, he refused to sign referral sheet, just kept walking." This patient came to this emergency room with a blood pressure in a range that is generally considered dangerously high. He did not receive an MSE and "walked out without treatment." This is the only comment to indicate disposition of this patient.

. . .

4. Patient 14 went to the emergency room 6/4/96, at 10:15 a.m. The nursing triage sheet documents the following as chief complaint and assessment. "Pain and swelling to left knee down to foot since yesterday. Diabetic. Left middle toe is black/necrotic [dying tissue], left middle hole to foot slightly reddened, a slightly foul odor noted, patient was seen by MD yesterday, spoke with private physician on telephone, updated regards patient complaint, private physician will see her in her office right away." Further documentation states "patient going to see private physician right away. Advised we would be glad to see her but insurance would probably not cover. Foot has been necrotic and is booked for amputation. Advised them to return if have further concerns." This patient with a leg swollen to the knee, a necrotic toe, and drainage from a hole in the foot with a foul odor came to the emergency room seeking emergency care. She did not receive that care, nor even a Medical Screening Examination.

. . .

10. Patient 8 was a 10-year-old boy brought to the emergency room on 12/1/95, by his mother. Chief complaint, "Dentist yesterday, now right side of face swollen and painful but not discolored." On antibiotics. "Advised the mother to talk to the business office regarding debts from previous visit. Mother and patient took off after going to the business office." Medical screening examination not done.

. . .

The above patients are patients that came to Alexian Brothers Hospital Emergency Room seeking medical evaluation and/or treatment and did not receive an MSE as required by the law in participating hospitals. There was no standardized procedure in place that would allow a Registered Nurse to be appropriately trained and monitored doing medical screening examinations. The facility's medical staff by-laws do not address nurses doing standardized procedures either in emergency room or in the Labor and Delivery Room, to determine that a patient is stable enough to be sent out of the hospital. (Continued next page)

Excerpts from HCFA Forms 2567 -- Violations confirmed in 1995 & 1996

These patients were randomly selected from in excess of 50 patients per month, that came to this emergency room for the prior six months from date of visit (6/25/96) seeking medical care and who are triaged to another health facility or to home without a medical screening examination (MSE).

Bellwood General Hospital
Bellflower, California

Based on interviews, review of the emergency department log, review of closed medical records, and review of policies and procedures, the facility and its staff failed to provide a medical screening examination within the capability of the hospital's emergency department to two patients who came to the emergency department seeking assistance. Although the hospital's emergency department is licensed as "stand-by, physician on call," in both instances described below, there was a physician and a registered nurse on duty and present in the emergency department at the time each patient came to the emergency department seeking care.

Patient #1, a 44-year-old Hispanic male, came to the emergency department around 0100 [1:00 a.m.] on August 13, 1995, complaining of severe abdominal pain. According to the patient, he was seen by a nurse who checked his blood pressure and pulse, told him that his pulse was "slow" and asked the patient about his insurance coverage. The nurse returned a few minutes later, told the patient that his insurance would not authorize treatment. The patient was not provided with a medical screening examination to determine the cause of his severe pain or the reason for his "slow pulse." The patient was told to seek care and treatment at another hospital. The patient's visit was not entered into the emergency department log and a medical record was not prepared.

The patient arrived at the emergency department of a second hospital at 0237 [2:37 a.m.]. Examination at the second hospital revealed the patient to be ill appearing. He had a sinus bradycardia (rate of 36) with frequent premature atrial contractions. Treatment with atropine raised the heart rate to 50. The patient's cardiac enzymes were elevated. The EKG was interpreted as "cannot rule out inferior infarct, age undetermined." He was admitted to the hospital's intensive care unit with a diagnosis of rule out myocardial infarction ("heart attack").

Patient #2, a 2-year-old male, was brought to the emergency department at 1417 [2:17 p.m.] on October 29, 1995. According to the medical record, the mother stated the child had an earache, cough and congestion. The medical record contains no documentation or any other evidence to indicate that a medical screening examination was performed on the patient. The only notation on the medical record states, "Authorization to treat was denied by Universal Care." The patient and his mother left the emergency department to seek care elsewhere.

Excerpts from HCFA Forms 2567 -- Violations confirmed in 1995 & 1996

Citrus Valley Medical Center -- Queen of the Valley Hospital "*Managed Care Issues*"
West Covina, California

Based on staff interviews, review of facility policies/procedures, review of the emergency room log and closed medical records, the hospital failed to provide a medical screening examination to 10 patients who came or were brought to the emergency department seeking examination and/or treatment.

The following patients did not receive a medical screening examination beyond initial triage because admitting personnel obtained financial information, contacted the patient's managed care organization, and received a denial prior to the performance of the medical screening examination.

Patient B, a 14-month-old male infant was brought to the emergency room by his mother on December 23, 1995, at 1:56 p.m. According to the mother, the infant had congestion and a cough of one day's duration. The infant was seen by a triage nurse who obtained vital signs and a brief history from the patient's mother. The infant was assigned a "delayed" triage category. Registration personnel contacted the patient's managed care organization and received a denial for treatment. No medical screening examination was performed. The mother and infant left the facility to seek care elsewhere.

Patient C an 18-year-old male, came to the emergency room at 1:50 p.m. on October 21, 1996, complaining of pain in the right hand with swelling. The patient was the driver in an auto vs. auto accident. After an initial triage evaluation the patient was assigned to the "fast track" for care. Registration personnel obtained financial information, contacted the patient's managed care organization and obtained a treatment denial. No medical screening examination was performed.

. . .

Patient E, a 1-year-old male, was brought by his mother to the emergency room at 5:22 p.m. on October 23, 1996. According to the mother, the child had a fever and had not been eating for two days. The triage nurse determined that the child had a temperature of 102.5, rectally. According to protocol, the child was given 160 mg of Tylenol at 1820 [6:20 p.m.]. Financial information was obtained, the managed care organization contacted and treatment denied. The child was sent to a clinic for the medical screening examination. Neither a repeat temperature check nor a medical screening examination was [ ] done prior to sending this febrile child and his mother from the emergency room to an outside clinic.

Patient F, a 17-year-old male, came to the emergency room at 4:16 p.m. on October 27, 1996. The patient had accidentally been hit in the head with an iron gate. Initial triage evaluation determined that the patient had swelling of the left eye. Triage assignment was to the "fast track" for care. Reception personnel obtained financial information and contacted the patient's managed care organization. The plan denied care but asked that the patient "go to clinic now." There is no documentation or other evidence to indicate that this patient with a potential head injury received a medical screening examination prior to being sent from the emergency room to a clinic for an examination.

Patient G, a 39-year-old male, came to the emergency room at 11:29 p.m. on November 6, 1996, complaining of "bad back pain." According to the medical record, the patient initially had pain after lifting a heavy weight earlier but the pain was now worse. The triage nurse took the patient's vital

signs and assigned a triage category of "fast track." Registration personnel obtained financial information, contacted the managed care organization, and received a treatment denial. There is no documentation or other evidence to indicate that the patient received a medical screening examination before being sent from the emergency room to receive care elsewhere.

Patient H, a 7-year-old male, was brought to the emergency room at 5:51 p.m. on November 13, 1996. According to the mother, the patient got hit in the mouth while running and had a loose tooth. Vital signs were taken by the triage nurse and the patient was assigned a "delayed" category. Reception personnel obtained financial information, contacted the patient's managed care organization and received a treatment denial. The medical record has no documentation or other evidence to indicate that the patient received an appropriate medical screening examination prior to being sent from the emergency room.

Patient I, a 50-year-old female, came to the emergency room at 12:33 p.m. on November 22, 1996, complaining of a swollen right eye for 4 days. The triage nurse took the patient's vital signs and assigned a "fast track" triage category. Reception personnel obtained financial information, contacted the patient's managed care organization, and received a treatment denial along with instructions to send the patient to a clinic for examination. There is no documentation or other evidence of a medical screening examination prior to discharging the patient from the emergency room.

Patient J, a 1-year-old female child, was brought to the emergency room by her mother at 1:40 p.m. on November 24, 1996. The mother stated that the child had pain in her left arm. The child had a history of asthma and was on medications. A triage nurse obtained vital signs and assigned the child a "delayed" triage category. Reception/admitting personnel obtained financial information, contacted the patient's managed care organization and received a denial for treatment. There is no documentation or other evidence to indicate that the child received a medical screening examination prior to leaving the emergency room.

Redbud Community Hospital
Clearlake, California

Patient "A", [an 11-month-old child], was brought to the emergency room on February 25, 1996 by his mother for follow-up treatment for continuing symptoms. In spite of the child's treatment with amoxicillin for bilateral otitis media and viral gastroenteritis, the child's condition showed no significant improvement and he remained febrile. Laboratory examination revealed that the patient condition was deteriorating, but no specific treatment was given. Three of the laboratory values were in the "panic" range, indicating the need for a rapid and intense response effort. Due to dehydration and potential sepsis the child's condition called for an intravenous line for appropriate treatment. Even though the emergency room physicians and staff were unable to achieve an intravenous placement, they did not utilize the hospital's on-call physicians. The on-call surgeon was not called for a surgical cut down to establish an intravenous line so that appropriate treatment could be given. Further, methods of hydration other than direct IV placement were not performed. After eight hours in the emergency room without receiving appropriate treatment, the patient was transferred to another medical facility. The emergency room physician failed to stabilize the patient prior to the transport. Soon after arrival to the other hospital's emergency room the patient suffered a cardiopulmonary arrest.

Victor Valley Community Hospital — *"Managed Care Issues"*
Victorville, California

Based on record review and interview it was determined that the facility failed to provide an appropriate medical screening examination to patients presenting to the emergency department. The findings include:

1. The emergency department log indicates that in the last 12 months 648 patients had their insurance denied during the initial admitting process to the department.

. . .

2. Patient #9 presented to the emergency department on 12/12/95 at 1514 hours [3:14 p.m.]. She arrived via ambulance with the complaint of a possible overdose. The patient has an insurance that contracts with another hospital for services. The facility called for authorization to treat and treatment was authorized with a note "if stable patient needs to be transferred to Saint Mary's." The patient was kept in the emergency department for over two hours and fifteen minutes. No treatment was given nor was there an on-going documentation of observation. The physician noted, "she is entirely stable" and transferred her via "airport shuttle" to Saint Mary's. The record at Victor Valley hospital indicated that the patient had a cardiac arrthymia before arrival (in the ambulance) and in the emergency department. This was not addressed by the transferring physician. The patient arrived at Saint Mary's hospital without any clinical paperwork and a physician to physician contact. The receiving physician stated it was too late to lavage her, as she was at Victor Valley hospital for over two hours without treatment.

3. Patient #6 presented to the emergency department on 12/15/95 at 1531 hours [3:31 p.m.]. He was brought in by ambulance. His complaint was "fell, chest pain, difficulty breathing." The tests done in the emergency department indicated the patient had fractured ribs and a hemothorax. The blood gases of this patient indicate that he was compromised, although this is not addressed by the physician. The physician documents that the "patient is felt to be too unstable to be discharged..." the patient had an HMO that did not admit to the facility so the patient was transferred.

. . .

5. Patient #7 presented to the emergency department on 1/6/96 at 2114 hours [9:14 p.m.]. He was brought in by ambulance with a complaint of chest pain and shortness of breath. The patient was treated in the emergency department. The emergency department physician documented his impression of the patient's medical status as the following, "1. chest pain, possible unstable angina. 2. pulmonary edema. 3. congestive heart failure. 4. hypertension. 5. IDDM [Insulin dependent diabetes mellitus]. " The patient's insurance is an HMO who does not contract with the hospital. This patient was transferred by ambulance over 50 miles so that he could be admitted to the HMO's hospital. There is no documentation in the medical record indicating the risks versus benefits of this transfer, which is purely financial.

6. Patient #8 presented to the emergency department on 3/5/96 at 0157 hours [1:57 a.m.]. The patient's complaint was, chest discomfort and a feeling of smothering. The patient was treated in the emergency department. The physician's impression was the patient had congestive heart failure and unstable angina. The patient's insurance is an HMO that contracts with another hospital. The patient was transferred at 0450 hours [4:50 a.m.] due to, "insurance coverage." There was no documentation as to the risks or benefits of this patient's transfer.

Screven County Hospital
Sylvania, Georgia

Individuals presenting to the emergency department had not always been provided a medical screening examination beyond initial triaging, which basically consisted of taking vital signs and statements of patients' complaint.

a) Emergency room (ER) patient #13, an eight-month-old child, was presented with complaint of "high temperature and crying at home". The licensed practical nurse (LPN) documented the chief complaint and vital signs. No triage level or evidence of medical screening examination had been documented prior to discharge of the patient by the LPN.

b) ER patient #14, a three-year-old child, presented with complaints, "fluid running from ear, child cannot hear." The patient was discharged by the LPN without evidence of a medical screening examination beyond triage.

c) ER patient #15 gave history of dental surgery one week previously and presenting with complaints of gum and ear pain. Following triage, a deposit of $20.00 and signature of a financial promissory note was requested prior to a medical screening examination. The patient stated she "would try to get the money." The patient did not receive medical screening beyond triage.

d) ER patient # 19 presented 2/22/96 with complaints of epigastric pain, dizziness, and a syncopal episode at work just prior to arrival. This patient was sent to the doctor's office for a medical screening examination.

2) The current "ER Policy For All Patients" dated 2/23/96, assigns triage responsibility to the emergency room nurse. A three level triage classification was utilized as follows: Level One equals non-emergency, Level Two equals urgent, Level Three equals emergent. The policy did not differentiate between triage and medical screening examinations or further define the requirements for a medical screening examination. Licensed practical nurses provide emergency nursing services 24 hours daily and have been designated the responsibility to discharge all patients who present and are triaged as Level One. The policy states that "if a patient (under managed care) wants to be seen, we will ask for $20.00 deposit and the promissory note to be signed."

3) Definition and authorization of who had been designated as qualified to perform a medical screening examination for emergency patients presenting to the hospital's emergency room had not been defined or approved by the hospital's medical staff or governing body.

Southwest Georgia Regional Medical Center
Cuthbert, Georgia

1) On 5/19/96, patient #16 was examined, treated, and discharged from the emergency room by non-physicians who had designated the responsibility to medically screen and treat emergency patients but did not have medical staff approval protocols.

2) A physician had been designated on call by the on-call physician list posted in the emergency room for 5/19/96, however, the physician was not called.

3) The medical screening examination performed for patient #16 was insufficient to determine if a medical emergency existed. Findings include: (a) Radiographs (x-rays) were not read (interpreted) as evidenced by staff and patient/family interviews and the lack of documented reports. (b) Incomplete examination as evidenced by: Extremities: no examination was documented. The patient and the ER record noted that a sling was applied to the left arm. The patient and staff recalled stated pain in both arms and per patient, the pain was worse in the right arm. Acromioclavicular separation was confirmed in the right arm by x-rays completed at another hospital. Lungs: the documented examination was limited to "CTAB" (clear to auscultation bilaterally). The patient reportedly complained of breathing difficulty. X-rays completed at another hospital confirmed "multiple fractured ribs, minimal atelectasis or contusion at the left lung base." Abdomen: the documented examination was limited to, "positive BS (bowel sounds) and positive for abrasions." Laboratory tests [or] surgical consultation, though available, were [?not] obtained. Same day admission to another hospital confirmed an elevated white blood count of 24.5 (normal range = 4.8 to 10.8). Surgical consultation confirmed that the patient's spleen had been lacerated.

4) On 5/19/96 patient #16, who was 10 weeks pregnant and presented to the ER after trauma sustained in a motor vehicular accident, remained in the ER one hour and 50 minutes and was then discharged to home. The medical screening examination completed by two non-physicians (one relieving another's tour of duty) was insufficient and inadequate based on the failure to assess and examine using ancillary services available, the failure to call the on-call physician although reportedly requested to do so by the family, and the discharge to home even though the screening examination was too limited to determine if a medical emergency existed. The patient's symptoms caused the family to take patient #16 approximately 40 miles distance to another hospital to determine if a medical emergency existed. The patient was then hospitalized and was on bed rest for seven days.

Doctors Hospital of Hyde Park — *"Managed Care Issues"*
Chicago, IL

It was determined on 11/14/96 that the ER physicians did not document medical screening exams on all HMO patients when treatment had been denied.

1. Patient was a 4-year-old child admitted to the ER on 11/9/96 at 0205 hours [2:05 a.m.] with complaints of elevated temperature, nausea times 3 days, a productive cough and pustules to the tongue. The patient had a history of asthma. The patient was triaged by the RN at 0205 hours [2:05 a.m.]. At 0215 [2:15 a.m.] the medical record documents the patient awaiting HMO approval. At 0235 [2:35 a.m.] HMO denied treatment, patient to report to clinic tomorrow. At 0245 hours [2:45 a.m.] the physician documents the ER visit denied will see patient at office in a.m. There is no documentation of a medical screening exam by the ER physician.

Excerpts from HCFA Forms 2567 -- Violations confirmed in 1995 & 1996

Minden Medical Center
Minden, Louisiana

In 7 of 22 records reviewed during this investigation, there failed to be evidence that these patients were stabilized before transfer to other facilities.

a) On 8/24/96 a 31-year-old female presented to the emergency room seven weeks estimated gestation age with complaint of severe intermittent cramping, abdominal pain and vaginal bleeding. Patient was transferred to another facility via private auto because there was no one in the hospital to perform ultrasound. Patient's diagnosis was "threatened abortion/rule out ectopic pregnancy." During the patient's one hour stay in the emergency room, only one set of vital signs was recorded.

b) On 7/4/96 a 59[?]-year-old presented to the emergency room with complaint of having fallen. The patient was transferred to another facility via ambulance after x-rays revealed a fractured hip. The transfer report completed by the ER physician indicated the possibility of fat embolus, yet the patient was transported without benefit of an IV access per hospital protocol during emergencies.

. . .

g) On 8/18/95[?] a 42-year-old male presented to emergency room with head trauma. Patient was "unresponsive" on admission, but "trying to breathe." The physician's plan included intubation, IV and Foley; however there was no documentation this plan was followed, other than starting an IV containing decadron. There failed to be a neurological assessment other than "Pupils dilated." Nursing neurological assessment was blank. There failed to be evidence the patient's head and neck were immobilized prior to transfer.

Springhill Medical Center
Springhill, Louisiana

According to the interviews, a mother and grandmother arrived at the emergency room with a six-year-old female patient on the evening of 8/4/96 with complaint of vomiting and high fever. They were told that since the patient's Medicaid card was not any good they would have to pay $50.00 prior to the patient being seen. The child was not examined.

Redington-Fairview General Hospital
Skowhegan, Maine

The hospital failed to effectuate an appropriate transfer by failing to supply qualified personnel and transportation equipment: patient presented to the Emergency Department with multiple symptoms including petechiae and an unstable blood pressure. Confirmed on interview with ED physician and the Director of Ambulatory Care, the patient's condition was deteriorating and she was acutely ill. The patient was transferred with ambulance EMTs in attendance and there was no documentation that this patient had a nurse or physician in attendance on transfer in spite of her acute condition.

Harrington Memorial
Southridge, Massachusetts

Two-year-old child was brought to the hospital's emergency room by her mother at 10:05 a.m. on 3/10/96. The child's temperature was 103.2 degrees Fahrenheit, and mother stated the child began vomiting and diarrhea earlier that morning. According to interview and medical record review, a medical screening exam was not conducted while the child was in the facility's emergency department. Medical record documentation indicated that the patient was referred to a physician's private practice at 11:05 a.m. Approximately seven hours later, child was taken to the emergency department by ambulance and was unresponsive upon arrival. She died at 5:59 p.m. that day.

Missouri Delta Medical Center
Sikeston, Missouri

1. Record review reveals that a 50-year-old patient came to the emergency department at 2:44 a.m. on 5/21/96, with epigastric pain, nausea, and shortness of breath. The patient complained of a "burning" sensation across the chest which occasionally radiated into the left arm and into the neck. The patient was "crying and holding his chest." The Cardiac monitor revealed sinus bradycardia at a rate of 55.

Documentation revealed that the pain was so intense at times, that the patient requested frequent pain medication. The following medications were administered to the patient between 3:40 a.m. and 5:30 a.m. with no improvement noted: Pepcid, Carafate, Donnatol, Xylocaine Viscous, three doses of Nitroglycerin, and Nubain. Record review reveals, "at time of discharge patient pacing in room, at one time kneeling on floor stating pain not relieved." The emergency room physician dismissed the patient at 6:30 a.m. in an unstable condition, as she was still experiencing severe pain. The patient was dismissed with instructions to use nitroglycerin and see her regular physician in the morning.

Upon dismissal the patient was take to another acute care facility where she was diagnosed as having an acute myocardial infarction (MI).

2. During an interview with the patient's daughter conducted at 9:45 p.m. on 7/10/96, it was stated that her mother was facing another angioplasty and that she hoped no one else ever had to experience a situation like this. The reference was to her mother's experience in the emergency department when she was screaming, moaning and pacing for over an hour in pain during which time no relief was offered, even after several requests had been made for pain relief.

3. During an interview on 7/10/96, at 7:45 p.m., with the nurse caring for the patient, it was stated that a request was made of the physician for something for pain. The response to this request was that he needed to see the patient first. A second request was made for pain medication and the response was that he wanted to wait until the laboratory results were obtained. On the third request the nurse stated, "if you don't want her to have a narcotic, could we give her something?" At that time 20 mg. of Pepcid, a gastrointestinal agent, was given with the patient reporting no relief from the pain. At this time the patient remained tearful while pacing back and forth in the room.

4. PRO review revealed that the patient had severe enough pain documented that admission for pain control and further evaluation was indicated.

Excerpts from HCFA Forms 2567 -- Violations confirmed in 1995 & 1996

Ripley County Memorial Hospital
Doniphan, Missouri

On 2/19/97 20 medical records were reviewed from the emergency room log. Three of those records were patients who presented to the emergency room for treatment and were not seen by a physician. All three of these patients resulted in undesirable outcomes. They are as follows:

On 2/5/97 at 0500 [5:00 a.m.], a 22-year-old female presented to the emergency room with the chief complaint of abdominal pain. The medical record stated that the pain started at approximately 6:00 p.m. the previous evening. She complained of nausea but had no vomiting. Her abdomen was soft with bowel sounds. Her color was pale. Her abdominal pains were sharp, and throughout her abdomen. The RN assigned to the emergency room charted that the patient's blood pressure was "faint" and she asked a second RN to come to the emergency room and assess the patient. The second RN charted the following: "blood pressure faint and read at 80/60. Asked patient if she had ever been told that she had low blood pressure or if she had a history of low blood pressure. Patient stated she had never had low pressure that she knew of. Left patient to inform ER nurse of blood pressure reading. ER nurse on phone with ER doctor. From overhearing ER nurse conversation, doctor referred to blood pressure as normal. Informed ER nurse blood pressure not normal for patient. . . . Abdominal assessment went as follows: Asked patient when pain started, patient replied "before supper at 1800." [6:00 p.m.] Asked if anything brought the pain on and patient stated no. Asked if there was anything that the patient had done or tried that eased the pain, patient replied no. . . Asked if pain was burning in nature and reply was no. Asked if pain was a dull ache and patient replied "yes" . . .Asked patient to lie down. Auscultated abdomen times nine quadrants. Listened to each quadrant approximately one minute. No sounds heard in any quadrants except left middle quadrant where a continuous whirring noise was heard and in left lower quadrant where heart beat was heard. . .Asked ER nurse if she heard bowel sounds and she replied yes in all four quadrants, almost hyperactive. Went back and auscultated abdomen for bowel sounds again. Still no bowel sounds auscultated. Whirring sound still present in left middle quadrant. Whirring noise unidentified. ER nurse back to care for patient." The RN assigned to the emergency room took over care of the patient. The physician on-call for the emergency room was notified per telephone and ordered a complete blood count, a urinalysis and a chemistry 7. The blood count was within normal limits. The urine test showed 1+ bacteria and 2+ mucous. A written statement from the RN on-duty in the emergency room stated the following: "Doctor on-call was given all information and lab results. She gave orders. When asked if she was going to see the patient, doctor replied "There's really nothing else I can do. Have her follow-up with her family physician in the A.M." Relayed information to patient and spouse. Told them they could "demand to see the Doctor if they choose to. They chose to follow-up with their doctor in the A.M." The patient was given a prescription for a urinary tract antibiotic and discharged from the emergency room with instructions to see her private physician the following morning. She was released from the emergency room at 0630 [6:30 a.m.]. According to the director of nursing at the hospital during an interview on 2/19/97 at 1700 [5:00 p.m.], the patient went to her private physician's office the same morning with continued complaints of abdominal pain. She went into cardiac arrest in the doctor's office and was transported back to the hospital emergency room. She arrived in the emergency room on 2/5/97 at 1130 [11:30 a.m.] in full cardiac arrest. Her skin was cold, radial pulses were unpalpable, her abdomen was very distended. Cardio-pulmonary resuscitation was initiated. The protocol[ ] for advanced cardiac life support was followed. An abdominal puncture at 1326 [1:26 p.m.] resulted in the removal of 300 cc's of bloody tinged fluid. At 1440, [2:40 p.m.] the patient was transferred per Lifebeat helicopter to a local hospital. She expired shortly thereafter.

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On 10/20/96 at 0630 [6:30 a.m.], a 51-year-old male presented to the emergency room with the chief complaint of "wheezing." His vital signs were as follows: Temperature 97.8, pulse 98, respirations 28 and a blood pressure of 130/92. He stated that he had been having trouble breathing for the past week. He complained of chest pain on the left side of his chest with relief from taking nitroglycerin tablets. The physician on-call for the emergency room was notified per telephone and ordered the following tests: EKG, chest x-ray, CBC, cardiac enzymes and a chemistry 6 profile. She also ordered a breathing treatment with proventyl. The results of the EKG were as follows: possible left atrial enlargement, inferior infarct, age undetermined, abnormal EKG. The chest x-ray was as follows: increase in the bronchovascular markings bilaterally, subsequently decreased from preceding study. Mild congestive heart failure could be present and should be correlated clinically. The physician assessment on the emergency room record stated the following: wheezing bilaterally, heart regular rate and rhythm without murmurs, abdomen soft and non-tender. The patient was discharged from the emergency room at 0825 [8:25 a.m.] with the following diagnosis: acute exacerbation asthma, diabetes. On 2/20/97 at 0940 [9:40 a.m.], the RN on-duty in the emergency room at the time of the incident was interviewed. She stated that although the physician made an entry on the medical record, the physician did not come to the emergency room when the patient was in the examining room. This same patient was admitted to the hospital on 10/27/96 with the diagnosis of acute congestive heart failure, acute exacerbation of chronic obstructive pulmonary disease, diabetes mellitus and hypertension.

On 10/20/96 at 1005 [10:05 a.m.], a 49-year-old male presented to the emergency room with the chief complaint of mid-sternal chest pain radiating to the left arm. The pain had been persistent for the past week. He complained of numbness and pain in his left arm. He stated that he had the pain with movement and at rest. His history includes smoking two packs of cigarettes per day. His vital signs were recorded as follows: temperature 97.2, pulse 72, respirations 24, blood pressure 162/108. The physician on-call for the emergency room was called per telephone at 1017 [10:17 a.m.] and ordered the following diagnostic tests: CBC, Chem 6, cardiac enzymes, EKG and a chest x-ray. The laboratory results were within normal limits. The EKG results stated "ST elevation, consider early repolarization, pericarditis or injury". The patient was given Procardia 10 mg, at 1050 [10:50 a.m.] for his elevated blood pressure. He was discharged from the emergency room at 1210 [12:10 p.m.] with the diagnosis of constipation, gas and acute bronchitis. Although the emergency room record was signed by the physician who was on-call, the patient was never seen by a physician while he was in the emergency room. On 10/21/96 at 1155 [11:55 a.m.], this same patient was admitted to the hospital with the diagnosis of antero-septal myocardial infarction. The hospital discharge summary stated the following: "This 49-year-old male with no significant past medical history was admitted on 10/21/96 with chest pain. He came into the emergency room and he was sent home and was seen by me in the clinic the following day where he was diagnosed with a myocardial infarction and admitted him." He was discharged from the hospital on 10/23/96 and was referred to a cardiologist.

Failure to complete a medical screening by a physician has the potential for a missed diagnosis which could result in a fatality or endanger the life of a patient.

Excerpts from HCFA Forms 2567 -- Violations confirmed in 1995 & 1996

Livingston Memorial Hospital
Livingston, Montana

Based on record review and staff interview, the facility failed to identify in the medical staff rules and regulations who can perform examination and treatments in the emergency room. Thirty-five medical records were reviewed. Of these, nine patients were sent to physician's office for care, three were treated by telephone orders to nursing staff and one left the facility after a 2 ½ hour wait. Findings include:

1. Patient reported to the emergency room at 11:30 p.m. on 2/13/93 with complaints of injuries to his/her head and hand. The patient stated s/he had told the nurse in the emergency department s/he thought s/he had broken his/her hand. The emergency room record documents the nurse's findings as "hit back of the head on shelf at work--blacked out momentarily--hit R [right] hand--knuckle to 5th digit somehow through all of this small bump top center of occiput; some swelling and superficial skin tear with some purple discoloration at R 5th digit, R 5th digit was intact." The physician was contacted and gave the following telephone orders: "head injury sheet, ice to R hand injury." The patient was discharged from the hospital without further screening. The patient was seen by his/her attending physician on 3/11/93 who ordered an x-ray. The report of this x-ray states the patient had a comminuted fracture involving the 5th metacarpal.

Mimbres Memorial Hospital
Deming, New Mexico

On 7/10/95, at 7:30 p.m., a woman in labor presented to the emergency department. She was admitted to the delivery area. The nurse was unable to detect fetal heart tones. At 8:00 and 8:10 p.m., the OB physician on-call could not be reached. At 8:14 p.m. his back-up was called. This physician refused to come stating "she was covering for the other physician, but not on-call for the hospital, and that she was leaving town in the morning and would not be on-call past midnight." She ordered an abdominal ultrasound and to transfer the patient ASAP.

At 8:35 p.m., the physician was contacted again to inform her that there was no technician to do the ultrasound. This physician called a hospital requesting a transfer. The receiving hospital would not accept the transfer without an evaluation and direct phone call from an OB attending. At 9:00 p.m., the ER physician made the decision to transfer the patient to another hospital. At 10:15 p.m., the patient continued to have uterine contractions every three minutes as documented by tachometer. Fetal heart tones were undetectable. At 11:35 p.m., the patient was transported via Lifeguard Helicopter to the receiving hospital. The medical record at the receiving hospital revealed that the infant was stillborn at 32 weeks gestation, due to Placenta Abruptio.

It was the obligation of the physician on-call to respond, examine the patient, and make the appropriate transfer, regardless of time of day or how near to her off-call time. At the time the patient presented to the hospital, they had the capability and capacity to provide medical screening and stabilization required by her condition.

If the physicians on-call for OB are not considered "on-call" to the hospital, they should not be responding to such requests. Both physicians routinely see patients at the request of the emergency room physician. Therefore, they are considered to be available for providing services when needed.

Erie County Medical Center
Buffalo, New York

A 19-year-old pregnant woman presented to the Emergency Department at 0005 [12:05 a.m.] on 1/14/96 with complaints of labor pains and contractions five minutes apart. The patient stated that she was 34 weeks pregnant and had delivered her first baby very fast without labor pains. The fetal heart rate was 124 and 128 by doppler. Patient was examined and found to be 2 cm dilated. Fetal monitoring and a sonogram were not done. Patient was discharged at 0120 [1:20 a.m.] with a diagnosis of "labor and contractions." The patient was discharged in an unstable condition.

Lake Shore Hospital
Irving, New York

Twenty-one of 29 patients transferred from the Emergency Room did not have documentation in their medical records specifying the risks and benefits of transfer; 4 of 29 ER transfers did not have complete documentation of patient vital signs taken prior to transfer. Patient transfers were not effected through qualified personnel and transportation equipment: 16-year-old patient with history of fetal alcohol syndrome and suicide attempts, was brought to the ER by his father who stated the patient threatened to kill him. The patient was allowed to be transferred by car with his father to a facility with an adolescent psychiatric unit despite documentation that there was a risk of the patient becoming violent and harming others.

Lockport Memorial Hospital
Lockport, New York

Patient who had previously undergone tubal ligation presented to the ER with severe lower abdominal pain. A urine for HCG was reported as positive and physician exam revealed suprapubic tenderness. The treated diagnosis was intrauterine pregnancy with final diagnosis also including rule out tubal pregnancy. The patient was discharged with instructions for strict bed rest, return to ER as needed, and follow up with private physician. Approximately one hour later, the patient was admitted to another facility where it was determined that she had a left ruptured tubal pregnancy with hemoperitoneum.

The medical screening exam was inadequate to determine the presence of an emergency medical condition as evidenced by the failure of the ER physician to: (a) address the patient's complaint of severe lower abdominal pain; (b) order diagnostic studies essential for the diagnosis of ectopic pregnancy; and (c) have the patient discharged from the ER with no diagnostic explanation of her lower abdominal pain and without ectopic pregnancy being ruled out sonographically and/or laparoscopically.

Lockport Memorial Hospital
Lockport, New York

Patient #1, a 66-year old male, presented to the ER at 3:03 p.m. on 9/10/96 with a complaint of midsternal chest pain. A 12 lead EKG interpretation read "inferior infarct, age possibly recent." Patient was discharged at 5:05 p.m. without evidence of a reevaluation and with a diagnosis of possible esophageal reflux/cardiac source ruled out. The patient returned to the ER at 11:25 p.m. with chest pain radiating down his left arm and was diagnosed with unstable angina/rule out MI and admitted to the ICU. The patient did not receive stabilizing treatment for his emergency medical condition during the first visit.

Medina Memorial Hospital
Medina, New York

Patient presented to the ER with abdominal pain due to blunt trauma. The patient was discharged 4 hrs 42 mins later with a diagnosis of abdominal muscle contusion. The next day the patient was admitted to another hospital with a diagnosis of splenic laceration with hematoma.

The medical screening exam that was done was inadequate to determine the presence of an emergency medical condition as evidenced by the failure of the ER physician to : (a) reevaluate the patient's abdomen; (b) adequately address the patient's complaint of significant pain after receiving pain medication prior to discharge; (c) make serial hemoglobin/hematocrit determinations; (d) have a CT scan of the abdomen done as a diagnostic tool for a possible splenic injury; (e) have a peritoneal tap done.

Mount St. Mary's Hospital
Lewiston, New York

The patient, a 28-year old woman, presented to the Emergency Department with severe abdominal pain on 3/3/95. The medical screening exam included a pregnancy test (positive) and vaginal exam. The patient was discharged with severe abdominal pain which had not been adequately investigated. She was readmitted three days later in shock with a ruptured ectopic pregnancy.

Excerpts from HCFA Forms 2567 -- Violations confirmed in 1995 & 1996

Hillcrest Medical Center
Tulsa, Oklahoma

Patient A, a 49-year-old female Medicaid recipient, presented to the Hillcrest Medical Center Emergency Room, in Tulsa, OK, Saturday, April 20, 1996. "Intractable" (L) hip pain was noted by the emergency room physician. An orthopedic consultation was ordered and the patient admitted for evaluation of "painful loose (L) Total Hip Arthroplasty."

In addition to pain, requiring medication with Demerol and Vistaril throughout the three-day Hillcrest hospitalization, significant temperature elevations persisted. Positive blood cultures were obtained early in the hospitalization. Temperature elevation, which began the afternoon of admission, reached 104.0 degrees Fahrenheit at 4:00 p.m. on the following day. The temperature was 102.1 degrees Fahrenheit at 4:00 a.m. on the 23rd of April, the morning of the transfer to University Hospital.

According to the Hillcrest Medical Center attending physician, an orthopedic surgeon, a call was placed to University Hospital in Oklahoma City Sunday evening, April 21. The Hillcrest physician stated he was seeking the name of the "joint man" at University.

The Hillcrest Medical Center physician told the surveyor he sought transfer for the patient because he felt the patient's situation called for a "rather heroic" operation. The patient had had bilateral total hip arthroplasty, with subsequent revision in 1980. The Hillcrest physician stated he felt he didn't have the skills to do such a procedure.

The patient's discharge summary, dictated by the Hillcrest physician, spoke of the patient's "continued acute pain about her left hip." The discharge summary further stated, "it was determined that she would require aspiration of the hip and then probable revision arthroplasty or possible removal of the prosthetic components, if indeed, a septic hip were discovered."

The Hillcrest Medical Center physician also dictated he had discussed the case with an orthopedic surgeon at University Hospital, in Oklahoma City, and that the physician "has agreed to accept the patient in transfer." According to the note, the University physician had "recommended that I transfer her to the University Hospital Emergency Room."

However, an entry in the patient's University Hospital medical record, written the day of her arrival at the facility, indicated the patient "was NOT accepted" by the specified orthopedic surgeon, "or any other member of the ortho service." On interview, the reported accepting orthopedic surgeon at University Hospital clearly stated he did not accept the patient in transfer.

According to the University Hospital surgeon, he was called by the Hillcrest Medical Center physician, "probably" the day before the patient's transfer to Oklahoma City. The conversation, as he recalled, was in regard to a patient with "a loose prosthesis." The University Hospital surgeon agreed, and he said his resident also agreed, to "see the patient in the orthopedic clinic." The University Hospital surgeon reported some additional discussion about the patient's pain. The Hillcrest Medical Center physician had reported that the patient had a "bladder infection."

(Continued next page)

The University Hospital surgeon admitted saying the patient could be "seen" in the emergency room. But, the statement was reportedly made in response to the Hillcrest physician's question of "what if" the patient couldn't wait for the clinic appointment and "what if" the patient's pain became too severe. The University Hospital surgeon stated he was not expecting the call that came the next day from the emergency room announcing "your patient is here."

According to interview with the attending physician on duty in the University Hospital emergency room when the patient arrived from Hillcrest Medical Center on April 23, 1996, the patient had an "unclear diagnosis." He stated she "had a lot of pus under her." The emergency room nursing assessment record indicates the patient presented with "copious, malodorous discharge between legs and on bedding beneath patient." Emergency department nurses notes state "Patient does not tolerate any movement", due to pain in the (L) hip. Another emergency nursing entry, documents changing of "blue pads" under the patient, indicated the pads were "filled with copious amounts" of yellow discharge. The note also mentioned that the procedure of changing the blue pads, "takes 4 staff." Subsequent anesthesia records reported the patient's height at 5'2" and weight of 214 pounds.

As a pelvic abscess was identified during the diagnostic work-up in the University Hospital emergency room, the patient was admitted to the general surgery service. A central line was placed for antibiotic therapy access and delivery of parenteral nutritional therapy. Excerpts from a physician progress note on April 24, state "she understands her current infection can be life threatening."

The patient was taken to surgery on April 25, 1996. The left hip was aspirated and "frank, purulent material" removed. An arthrogram was performed which showed communication of the hip joint with the fluid collection in the pelvis. Removal of the prosthesis was accomplished. The patient was discharged home May 6, 1996, to be followed in the orthopedic clinic.

The Hillcrest Medical Center orthopedic surgeon stated he sought transfer because he felt he did not have the skills to perform the type of "heroic" procedure the patient required. A review of credential files indicated his privilege delineation included "Arthroplasties and Replacement of any Joints, Total or Partial by means of Artificial Appliances."

Medical staff records at Hillcrest Medical Center also indicate that 27 other orthopedic surgeons are also staff members, categorized as either "Active", "Courtesy" or "Provisional" members. An additional four orthopedic physicians are listed as "Honorary" members of the medical staff.

According to Hillcrest Medical Center administrative staff, the hospital had the capacity and capability to provide emergency surgery treatment for the patient. Twenty-four hour in-house operating room staff, and back up crews were stated to be "always available." Indexed medical records at Hillcrest Medical Center reflect 19 total hip revision surgeries have been performed at the hospital in the last four years.

De Leon Hospital
De Leon, Texas

After evaluation by the nurse and physician assistant at hospital A, this patient was found to be in "early stages of term pregnancy": estimated gestation greater than 8 months; onset of contraction one hour previous, frequency every 8 minutes, duration 5 to 7 seconds; dilated 3 centimeters; effaced 60%. This patient was instructed by personnel of hospital A to go by private car to hospital B, a distance of 22 miles. Forty minutes later, this patient arrived at hospital B; she was completely dilated, and delivered 50 minutes after arrival.

Harris Methodist Fort Worth
Fort Worth, Texas

This patient, [patient #1], age 37, presented at the emergency department of hospital H [this hospital]. Medical evaluation by the emergency room physician revealed the following: Blood count results were abnormal: low hemoglobin of 4.4 (normal lower level=11.5); low hematocrit of 14.7 (normal lower level=34). Presenting complaints included, "increasingly weak."

Further medical examination and treatment to stabilize the emergent medical condition, severe anemia, was not provided. Staff and facilities to treat patients with anemia were available at hospital H, which routinely provided internal medicine services.

This patient was discharged home with an unstabilized emergent condition. Discharge instructions were to call physician K the next day for follow up at that physician's office.

Eleven [and] one-half hours after discharge from hospital H, patient #1 was taken by ambulance to hospital M. On arrival at hospital M, cardiopulmonary resuscitation was in progress. Blood pressure and pulse were not obtainable. Hemoglobin was 3.9 (normal lower level=11.5). After 2 ½ hours of unsuccessful resuscitative efforts, patient #1 was pronounced dead.

Martin County Hospital District
Stanton, Texas

A review of 32 randomly selected records of patients who had presented to the Emergency Department between 1/1/96 through 8/13/96 revealed that of the 32 patients, 10 did not receive an appropriate medical screen. Medical records numbered 3,7,8,12,17,18,20,21,25,29. Three of the medical records of patients who were evaluated did not contain continuing medical evaluation of the patient's condition as required per regulation when an emergency medical condition exists. Medical records numbered 17,20,29.

Examples are, but not limited to:

#7: Pain medication given, no response recorded; no repeat of vital signs.
#25: Patient presented with term pregnancy, no documented fetal heart tones.
#18: Patient received injection of medication for pain, no documentation of relief of symptoms as the patient had been discharged three minutes after the injection.
#21: Patient was [?]-year-old with a fractured humerus with displacement. There was no documentation of the pulses of the affected am. The patient was discharged from the Emergency Department with explicit instructions and directions to go to the Emergency Department in a city over 100 miles away. The patient was determined not to have an emergency medical condition.

Determined to have an emergency medical condition:

#17: The patient, diagnosed with an acute myocardial infarction, was admitted to the emergency department at 0800 [8:00 a.m.] when his vital signs were taken. The patient was transferred to another facility for a higher level of care at 0925 [9:25 a.m.]. No further vital signs were recorded as having been taken before transfer.

#20: The patient, diagnosed with chest pain and chest pressure, was admitted at 2300 [11:00 p.m.] to the emergency department. The vital signs for this patient were recorded as having been taken at 2300 [11:00 p.m.] and 2315 [11:15 p.m.]. During the stay in the emergency department the patient received nitroglycerine x 2, morphine sulfate intravenously x 2, aspirin, and the Streptokinase infusion per protocol. There were no further vital signs, nor was there evidence that the patient had been on a cardiac monitor during his stay in the emergency department.

#29: The patient . . . was present in the hospital for x-ray and laboratory procedures from 1005 [10:05 a.m.] on 3/14/96 until she was written in as an emergency room patient at 1050 [10:50 a.m.]. There was no physical assessment by the registered nurse on duty, no continuing vital signs, and no assessment performed by the respiratory therapist on duty. The record did not contain a complete physical assessment by the physician who was present in the Emergency Room at the time of the patient's arrival. The patient's condition upon admission was listed as "poor" and according to the physician's documentation and the documentation of the receiving hospital and the ambulance run sheet, the patient did have an emergency medical condition. There was no attempt to stabilize the condition prior to transfer. The physician ordered an intravenous solution to be started in the ambulance as there was none running. The physician had ordered a "breathing" treatment for the patient, but none was recorded as having been done. The patient was transferred to the receiving hospital within 10 minutes of the time she was logged in to the Emergency Room.

Augusta Medical Center [AMC]
Fishersville, Virginia

The patient was diagnosed by the Emergency Department physician as having: positive patella fracture and positive wrist fracture. The ED physician failed to document that the fractures were non-displaced (left wrist) and comminuted, displaced (1cm), requiring surgical reduction and internal fixation (left patella). There was no documentation that the ED physician described the fractures to the on-call orthopedic surgeon.

. . .

Less than 24 hours (discharge on 6/3/94 at 2052 hours [8:52 p.m.] to admission on 6/4/96 at 1111 hours [11:11 a.m.]), the patient was admitted by orthopedic surgeon to AMC, and scheduled for surgery for an open reduction with internal fixation on the patient's left patella.

The ER physician discharged the patient home in improved condition. The "improved condition" is compared with following documentation noted in the medical record:

*Radiological Report records a transverse comminuted fracture across the mid-body of the patella. There is approximately 1cm displacement of the fragments.

*The patient received no crutches as ordered, the reason documented was "Canadian crutches not in ER".

*The patient's discharge instructions did not address a fractured knee.

*The patient's discharge instructions, which stated: "My signature indicated that I understand, and have received a copy of, the above instruction," was unsigned.

*The Emergency Department Physician Record documented that the patient (height 5'2" and weight 121 pounds) received a total of 100mg Demerol and 50mg Phenergan for pain while in the Emergency Department. The nurse documented at 2200 hours [10:00 p.m.] "Patient given 6 Tylenol with Codeine to go for pain until AM. Patient taken to car in wheelchair. Complaint of left knee pain."

*The patient stated that when she arrived home after leaving the Emergency Room, it took three people to carry her (two to lift her and one to hold her left leg). The patient and her husband never received the reason from the ED physician why she was not admitted for further treatment while in the AMC Emergency Room.