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update

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Hospital Liability

EMTALA “Patient Dumping” Claim May Proceed Despite Hospital Admission

In a case of first impression in the 3rd Circuit, which includes Pennsylvania, the court in Mazurkiewicz v. Doylestown Hospital, et al. 2004 WL 329382 (E.D. Pa) (February 17, 2004) recently faced the question of whether a patient, who was admitted to a hospital from the emergency room and treated for several days, can argue that he was never “stabilized” and thus seek relief under the Emergency Medical Treatment and Active Labor Act (“EMTALA”) for alleged “patient dumping” after he was discharged from the hospital. Utilizing other federal circuit appellate case law decisions, Judge Brody held that a patient’s hospital admission from the emergency room is a defense to EMTALA liability “so long as the admission is not subterfuge.”

Section 1867 of the Social Security Act (42 U.S.C. sec. 1395dd) requires hospitals with emergency departments to medically screen anyone who “comes to the emergency department” seeking treatment for a medical condition so as to determine whether an “emergency medical condition” exists. If the patient has an emergency medical condition, the hospital must provide “stabilizing” treatment and follow prescribed conditions and procedures if the patient is transferred to another facility. The term “stabilized” is defined in the statute as “no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility.” 42 U.S.C. sec. 1395dd(e)(3)(B). Any individual who suffers personal harm as a direct result of a hospital’s violation of EMTALA may obtain damages available for personal injury under the law of the state in which the hospital is located. 42 U.S.C. sec. 1395dd(d)(2)(A).

The underlying facts of the Mazurkiewicz case are as follows: on February 19, 2001, Mr. Mazurkiewicz arrived at the Doylestown Hospital emergency room, with complaints of sore throat, sinus pressure, swollen glands, achiness, painful swallowing and difficult breathing. An ear, nose & throat specialist (ENT) examined the patient and ordered a CT scan which indicated “severe pharyngitis, possible abscess.” In the ENT specialist’s mind, a neck abscess was a potentially life-threatening condition. In addition to the CT scan, the ENT specialist performed a fine needle aspiration partly for diagnostic purposes and to obtain bacteria for culture, if there was an abscess. The ENT specialist was unable to aspirate any fluid for culture and ruled out abscess as a

possible diagnosis. The patient was then admitted by the ENT specialist to the ICU out of concern for developing an abscess. Between February 19, 2001 and February 24, 2001, the patient remained a patient at Doylestown Hospital, undergoing tests, treatment and observation, showing steady improvement throughout the admission. Mr. Mazurkiewicz was discharged from the hospital on February 24, 2001 at 12:45 pm, with instructions to contact the ENT specialist if his symptoms worsened.

After returning home on February 24, 2001, Mr. Mazurkiewicz developed a fever and his wife suggested going to Hunterdon Medical Center, where she worked, instead of returning to Doylestown Hospital. At 8:17 pm on February 24, 2001, Mr. Mazurkiewicz was seen at Hunterdon Medical Center’s emergency room where he was subsequently diagnosed with parapharyngeal space abscess with retropharyngeal space involvement. Emergency surgery was performed to secure the patient’s airway and for abscess drainage. During surgery, it was determined that a tracheotomy was necessary to protect Mr. Mazurkiewicz’s airway, given the extensive neck swelling and inability to secure his airway. The patient was discharged on March 3, 2001.

The Mazurkiewicz’s subsequently filed a lawsuit and submitted expert reports indicating that Doylestown Hospital and their physicians failed to meet their EMTALA obligations in failing to stabilize Mr. Mazurkiewicz’s emergency medical condition prior to discharging him from the hospital. Doylestown Hospital moved for summary judgment regarding the Mazurkiewicz’s EMTALA violation claim, stating that the patient’s allegations should be dismissed because Mr. Mazurkiewicz was “stabilized” prior to his discharge. In reply, the plaintiffs argued that because Mr. Mazurkiewicz was discharged with the same condition with which he was admitted and had to have emergency surgery less than eight hours after his release, he remained in a life-threatening condition for the entirety of his stay at Doylestown Hospital and was never “stabilized” as EMTALA requires.

Judge Brody observed that the federal circuit courts were divided on the extension of EMTALA protection to patients who were initially treated in the emergency room and then subsequently admitted to the hospital. Some circuits refused to extend EMTALA, explaining that the statute was not a federal malpractice suit, but was an

“anti-dumping” statute meant to “get patients into the system who might otherwise go untreated and be left without a remedy because traditional malpractice law affords no claim for failure to treat.” Further, some circuits refused to extend EMTALA because they held the term “stabilize” was not intended to apply to those individuals who are admitted for inpatient care, and after an admission for inpatient care, state tort law would provide a remedy for any alleged negligent treatment. However, other circuits had extended EMTALA, reasoning that “patient dumping” was not limited to emergency rooms, noting that such limitation would allow hospitals to be relieved of their liability based on the technicality of where in the hospital a plaintiff had been treated.

Taking into consideration the differences between the circuit courts on this issue, Judge Brody synthesized the differing holdings and created a new standard: Hospital admission of a patient from the emergency room will remain a defense to EMTALA liability so long as the admission is not considered subterfuge of the act. Applying his standard to the facts of the case, Judge Brody held, that given the five-day Doylestown Hospital admission, he would have to find that the patient was deliberately admitted as a ploy to avoid the EMTALA act. Having no evidence that this was the case, along with the fact that the ENT specialist documented improved patient condition, the EMTALA claim was dismissed.

In light of the holding in Mazurkiewicz v. Doylestown Hospital, a patient’s hospital admission from the emergency room is not a “blanket” defense to EMTALA claims in Pennsylvania. However, despite the Mazurkiewicz ruling, it appears that it remains difficult to make a prima facie civil EMTALA claim when the patient is admitted from the emergency room, in the absence of information or evidence that there was an effort by the hospital or its physician to admit the patient as a “ploy” to avoid responsibility under EMTALA.

Mark T. Perry, Esquire

winter/spring 2004

Supreme Court Outlines MCARE Fund Involvement in Settlement Apportionment

In Milton S. Hershey Medical Center v. Commonwealth of Pennsylvania Medical Professional Liability Catastrophe Loss Fund, 821 A.2d 1205, (Pa. 2003), the Supreme Court held that the MCARE Fund's ("Fund") coverage for a hospital's vicarious liability regarding a physician's negligence was not implicated where the primarily liable physicians had sufficient insurance to finance the settlements of both actions.

The case involved an action brought by the hospital against the Fund for refusal to pay malpractice claims for vicarious liability until all excess coverage was exhausted. The Commonwealth Court held that the Fund could refuse to pay for the hospital's vicarious liability until the physician's liability coverage was exhausted, and the Supreme Court affirmed this decision.

The court stated that the best way to conceptualize the layers of insurance in this instance is to imagine two columns, each with four layers; the first column showing the insurance the Hospital obtained for its physicians and the second showing the apparently identical coverage it obtained on its own behalf. The bottom level of each column represents a \$200,000.00 self-insured layer of basic coverage. The next level shows the \$1,000,000.00 Fund limit of liability. The third layer is a self-insured excess layer of \$3,000,000.00. The fourth layer represents a \$25,000,000.00 layer of excess insurance.

In situations where a Plaintiff sues a hospital physician and asserts vicarious liability, a settlement

involving \$200,000.00 would not require recourse to the hospital's column of insurance because the primarily liable physician has sufficient insurance coverage to finance the settlement. A case with a settlement value of greater than \$1,200,000.00 but less than \$1,400,000.00 would also not raise the issue because regardless of where the additional \$200,000.00 comes from the physician's self-insured excess layer or the hospital's self-insured primary layer, the resources for the settlement would come from the hospital.

The issue arises when the settlement amount is in excess of \$1,400,000.00. That was the case in Milton Hershey. This type of settlement requires a determination of whether settlement amounts must be paid from the level representing \$3,000,000.00 in self-insured excess coverage or the statutory Fund coverage for the hospitals. In Milton Hershey, the Fund argued that the additional settlement of funds should come from the hospital's excess insurance layer. The relevant authority is found in 40 P.S. § 1301.705(a), which provides:

No insurer providing excess professional liability insurance to any health care provider eligible for coverage under the fund shall be liable for payment of any claim against a health care provider for any loss or damages except those in excess of the fund coverage limits.

40 P.S. § 1301.705(a).

The hospital interpreted the statute to mean that no excess insurance may be paid until the Fund

pays the \$2,000,000.00 statutory maximum for the physician and the hospital. The Fund argued that the statute provided that an excess insurer of the physician health care provider need not make payment unless the loss exceeds the Fund coverage limits for that provider.

The Supreme Court held that the statute was ambiguous regarding the issue of whether the Fund should be required to make the additional \$1,000,000.00 payments from the hospital policy as a result of the vicarious liability claims asserted against it. To ascertain the intent of the legislature, the Court looked to the legislative history, and stated that the purpose of the Health Care Services Malpractice Act was to reduce the cost of primary insurance rates by creating a fund to pay claims that are more than the basic medical malpractice insurance policy carried by a health care provider.

The Court found that the hospital's position was inconsistent with the policy of the Act to reduce the cost of primary insurance coverage and maintain the solvency of the Fund. The hospital's approach only favored the hospital, not the goals of the statute. It also depleted the Fund and would reduce the amount of money available to other medical malpractice victims. The Court found that the position of the Fund was more consistent with the purposes of the statute. Accordingly, the Fund's coverage of the vicarious claims against the hospital was not implicated because the physicians' coverage was sufficient to satisfy the claims.

Cindy A. Sheridan, Esquire

Burden of Proof

Use Of Res Ipsa Loquitor Doctrine Limited in Medical Malpractice Cases

In Toogood v. Owen J. Rogal, D.D.S., P.C., 824 A.2d 1140 (Pa. 2003), the Court directly confronted the application of *res ipsa loquitor* in medical malpractice cases stating that the doctrine must be carefully limited, because whether a particular error on the part of a physician reflects negligence demands a complete understanding of the procedures the doctor is performing and the responsibilities upon him at the moment of injury. The Court adopted Restatement 2d, Torts Sec. 328D as the standard of law to be followed and pursuant to 328D, three conditions must be met before the doctrine of *res ipsa loquitor* may be invoked:

(a) either a lay person is able to determine as a matter of common knowledge, or an expert testifies, that the result which has occurred does not ordinarily occur in the absence of negligence;

(b) the agent or instrumentality causing the harm was within the exclusive control of the defendant; and

(c) the evidence offered is sufficient to remove the causation question from the realm of conjecture, but not so substantial that it provides a full and complete explanation of the event.

It is only when each of the three conditions are satisfied that an inference of negligence can be drawn from the occurrence of an injurious event. As dictated by Section 328D, the applicability of the doctrine depends, in the first instance, upon whether the damaging event ordinarily does not occur in the absence of negligence.

The Court set forth several public policy reasons why *res ipsa loquitor* should be limited in relation to medical malpractice actions against physicians. Public policy reasons exist for protecting physicians by limiting *res ipsa*

loquitor inferences in medical cases, which must be weighed against the policy concerns of protecting the general public. First, doctors hold an important place in our society due to the role that they play in the health and even survival of the peoples of this nation. For that reason, society should not allow a doctor's actions to be second-guessed at trial without a clear understanding of the standards required. Second, medicine is not an exact science. Much discretion exists in a doctor's practice of medicine that should not be condemned in hindsight. Third, the practice of medicine is a complex and experimental field. Therefore, expert testimony is necessary to prevent a finding of liability for a simple mistake of judgment, failure of treatment, or an accidental occurrence.

Salvatore Savatteri, Jr., Esq., MHA

Expert's Investigative Methodologies Not Subject to Frye Inquiry

In the case of Tucker v. Community Medical Center, 2003 W.L. 22161438 (Pa. Super. 2003), the Superior Court refined the Frye standard regarding expert witness testimony. In this case, the Plaintiff, and his wife, brought a medical malpractice action and a loss of consortium claim against a medical center and a physician alleging that the nurse and doctor used excessive force in attempting to insert the catheter and perforated the lining of the Plaintiff's urethra thereby causing him to develop "strictures" and "false passages" that resulted in urologic complications and sexual dysfunction. The Court of Common Pleas, Lackawanna County, Civil Division, No: 96-CV-4450, (Judge Nealon) entered judgment for the Defendant doctor and medical center and the Plaintiff and his wife appealed.

On appeal the Plaintiff and his wife raised the question of whether the Trial Court abused its discretion in failing to conduct a Frye inquiry upon the medically unreliable expert opinion presented by the Defendant physician and Defendant medical center that a Foley catheter does not cause perforation and creation of false passage out of the urethra.

The Superior Court stated that the Frye test sets forth an exclusionary rule of evidence that applies only when a party wishes to introduce novel scientific evidence obtained from the conclusions of an expert scientific witness. Trach v. Fellin, 817 A.2d 1102 (Pa. Super. 2003). The Court reasoned that under Frye, a party wishing to introduce such evidence must demonstrate to the trial court that the relevant

scientific community has reached general acceptance of the principals and methodology employed by the expert witness before the Trial Court will allow the expert witness to testify regarding his or her conclusions. The Court noted, however, that conclusions reached by the expert witness from generally accepted principals and methodologies need not also be generally accepted. Therefore, a Court's inquiry into whether a particular scientific process is "generally accepted" is an effort to insure that the result of the scientific process stems from "scientific research which has been conducted in a fashion that is generally recognized as being sound and is not the fanciful creations [sic] of a renegade researcher". Blum v. Merrel Dow Pharms., Inc. (Pa. 2000).

The Superior Court held that in the present case, Frye was inapplicable because the expert's opinion testimony regarding whether a Foley catheter caused a "false passage" and whether the Plaintiff suffered from a pre-existing medical condition that rendered him susceptible to this particular type of injury was not, nor could it be considered, novel scientific evidence. In support of its reasoning, the Superior Court specifically stated that in the present case of Tucker, the diagnosis and evaluation in a medical context are, in a sense, scientific, yet the methodologies that were used by the expert in this case to diagnose and evaluate the Plaintiff (reliance on scholarly journals, review of medical records and examination of the Plaintiff) were not novel and the Plaintiff and his wife failed to produce evidence that they were novel.

The Superior Court analogized their holding in the present case of Tucker to their holding in the case of Commonwealth v. Passarelli, 789 A.2d 708, 716 (Pa. Super. 2001), where they held that expert opinion testimony with respect to "shaken baby syndrome" offered to prove intentional misconduct on the part of the Defendant was not "scientific evidence" within the meaning of the Frye test. Likewise, the Court stated that in the present case of Tucker, the Defendant's expert testimony was offered as a means to explain that the Plaintiff would have been injured even if the Defendant physician and Defendant medical center would have followed the accepted standard of care, and, therefore, it was not "scientific evidence" within the meaning of Frye.

As such, the Superior Court in Tucker refined the Frye test and held that reliance on scholarly journals and review of medical records and examination of a Plaintiff were not novel evidence, but were mere methodologies used by the expert witness to reach his conclusions in the case. The Superior Court specifically stated that this type of evidence need not be generally accepted by the scientific community. Therefore, the methodologies used by an expert witness to diagnose and evaluate a Plaintiff in a medical malpractice case will not be subject to the Frye test.

John Hill, Esquire

PIGA Offset Does Not Apply When Claims For Past Medical Expenses Are Formally Withdrawn

In Brostoski v. Luccino, M.D., et al., 2003 W.L. 22435565 (Pa. Super. 2003), the Pennsylvania Superior Court held that plaintiff's past medical expenses did not constitute a PIGA settlement offset where plaintiff's counsel formally withdrew his client's claim for these economic damages prior to trial. It is well-known that the PIGA statute contains a non-duplication of recovery provision that prohibits a plaintiff's recovery for past medical expenses that were paid by a privately owned and operated health insurance carrier. In the Brostoski matter, plaintiff's counsel withdrew his client's claim for recovery of past and future medical expenses prior to trial

and proceeded only for recovery for his client's pain and suffering. During trial, plaintiff's counsel settled with the defendant, who was being defended through PIGA, in the amount of \$35,000.00. Despite plaintiff's counsel's formal withdrawal of the claim for past medical expenses (totaling \$5,691.95), PIGA tendered a settlement check in the amount of \$29,308.15 which reflected an offset of monies paid from the plaintiff's private health insurance carrier. Subsequently, the plaintiff filed a petition to enforce settlement in the amount of \$35,000.00, which was granted and was subsequently appealed by PIGA to the Superior Court.

The Superior Court, in affirming the

lower court's ruling, enforced settlement for \$35,000.00. The Superior Court held that the only reasonable reading of the PIGA offset provision (40 P.S. Sec. 991.1817) was to require the claim to be offset for the same loss as the claim asserted against the insolvent insurer. At the time of settlement in this instance, the plaintiff's only formal claim was for pain and suffering. Since the settlement did not contemplate recovery for the plaintiff's prior medical expenses, the PIGA offset provision was not applicable.

Caroline Miller, Esquire

Question Answer

Is a stay of proceedings imposed in civil litigation involving a member of the United States Armed Forces?

Yes. Service to our nation by members of the United States Armed Forces often times compromises the service member's ability to assert their legal rights.

As a result, federal and state lawmakers have enacted legislation to protect service members. The Soldiers & Sailors Civil Relief Act ("Act") is one such piece of federal legislation that protects the legal rights of service members.

The Act allows a service member who is either a plaintiff or the defendant in a civil lawsuit to request a stay of a court proceeding in which he/she is a party. The service member may request a stay at any point in the proceedings. This provision of the Act only applies to civil lawsuits, suits for paternity, child custody suits and bankruptcy debtor/creditor meetings.

Paul Wylam, Esquire

case alert

Delinquent 605/715 Claim No Longer Subject to "Prejudice" Requirement

In a previous issue, it was reported that the Commonwealth Court required an additional finding of "prejudice" to the Fund in order to reject a delinquent 605/715 coverage request. In a decision issued February 18, 2004, the Pennsylvania Supreme Court reversed the Commonwealth Court's opinion and held that the 180-day limit on a 605/715 coverage request would not be subject to a prejudice requirement. PMSLIC v. The Medical CAT Fund, 2004 WL 305993 (Pa. 2004). Therefore, it is anticipated that the Fund will enforce strict adherence to the 180-Day requirement on all 605/715 claims.

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